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Lived Experiences: An Examination of Older Adults' Late-stage, Life-span Ecological Transition from a Home Residence to an Assisted Living Facility

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LIVED EXPERIENCES: AN EXAMINATION OF OLDER ADULTS' LATE-STAGE, LIFE-SPAN ECOLOGICAL TRANSITION FROM A HOME RESIDENCE TO AN ASSISTED LIVING FACILITY

by

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Abstract

The population of older adults in the United States is growing rapidly, and in response to demographic changes, a new housing market for elders known as assisted living is emerging as the fastest growing segment of the senior housing arena. While the impact of the transition to institutional facilities has been examined thoroughly in settings such as nursing homes, little is known about the influences of a late-life transition to assisted living (AL) on American elders. Using a phenomenologically oriented approach, this qualitative investigation examined the lived experiences of assisted living residents as a means of adding to the literature about the key developmental issues for elders and making recommendations for human services professionals who work with this population. The results of the investigation reflect fairly consistent findings about the reasons that elders move to assisted living. Health problems contribute much momentum to the transitioning process, as, it seems, do Western cultural values on individualism. The findings illuminated environmental concerns about social disconnectedness and a lack of challenging and meaningful activities within assisted living communities that have the potential to act as barriers to AL residents' positive development. Another concern for elders who relocate to assisted living is the potential loss of autonomy when real and perceived opportunities for self-initiated decisions are not readily available to residents. The results also provided evidence that opportunities for personal enhancement, relationship development, and community service are possible for elders who live in assisted living. These factors, which contribute positively towards human growth and development in the late-life stage and which confront cultural stereotypes about older adults and the aging process as a period of decline, are bolstered when older

adults are in autonomy-supportive environments, have opportunities to forge meaningful relationships, and engage their sense of competence.

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As I consider the journey I have walked over the past few years of study and research, I am keenly aware of all the people who have supported and inspired me on this great excursion. First, I am grateful for the many older-adult friends I made in my work as a pastoral minister. These men and women, who I encountered in their homes and institutional settings, drew me into their worlds and became the inspiration for this inquiry. I hope that this closer examination of their lived experiences has become a witness to the sometimes forgotten-or-ignored joys and difficulties they face when transitioning from their homes to assisted living facilities.

Second, I am grateful to the faculty of the Duquesne University School of Education and to my wonderful committee: Dr. Jocelyn Gregoire, Dr. Lisa Lopez Levers, and Dr. Emma Mosley. Jocelyn, you encouraged me three years ago to apply for the doctoral program, and with each road bump I encountered along the way of my studies, you stood by me, reminding me that I could succeed. The sacrifices you foretold as part of the quest for a doctoral degree, I did indeed have to make, but those sacrifices have certainly been worth the prize! Thank you for your sturdy, rock-like confidence in me! Dr. Levers, you introduced me to the world of qualitative research, and your own excitement for being a professional counselor educator and diligence as a researcher have been an inspiration to me. Thank you for pushing me to go beyond “good work” and to strive for “the excellent.” Dr. Mosley, you have been my moral support, always willing to listen in my moments of need! Thank you for keeping your door open and for sharing the wisdom of your experience with me.

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Old age, especially in the last, hard years, is really a search for a place in the universe, both figuratively and literally. The old look for their existential place. They ask, "How did my life matter?" "What can I look back on with pride?" "Did I love the right people?" And, they search for a home and a village where they will be comfortable, useful, and loved.

Pipher (1999, p. 15-16)

CHAPTER I

THE INQUIRY

The later years of life long have been touted as the "golden years." In the shine and shimmer of this coveted era are reflected often anticipated moments such as retiring, becoming a grandparent, traveling, and enjoying the companionship of friends, family, and other retirees. While events like these are something like a glossy coat that protects and enhances the golden quality of the late-life experience, there also are some inescapable transitions and losses that accompany later adulthood and have the potential to tarnish this precious period of life.

The interest at the heart of this study is a late adulthood transition experience that occurs when older Americans relocate from their home residences to long-term-care sites known as assisted living facilities. Relinquishing their homes, property, and possessions and moving to an institutional setting is a major decision for American elders. The potential losses associated with a move to long-term-care facilities are great, and the corrosive effects of institutional living are very real.

A foundational question for this piece of research, therefore, is: How do older adults experience the late-stage, life-span transition when they permanently relocate from a home residence to an assisted living facility? To respond thoughtfully, purposefully, and deeply to this inquiry, a qualitative approach has been used to examine the lived experiences of older adult residents of assisted living facilities. Theoretically, the study has relied largely on developmental perspectives, with preference given to a bio-ecological framework that accounts for a diversity of individual and environmental factors. Specifically, this study has been cast against Bronfenbrenner's (1979; 2005)

theory of human development and Ryan and Deci's (2000; 2006) self-determination theory (SDT).

Importance of the Study

Two facets of the American demographic provide considerable importance to this investigation: (a) the population of older adults in the United States is rising rapidly, and (b) assisted living facilities are the fastest growing segment of the senior housing market (Citro & Hermanson, 1999; Steinhardt, 1997).

A favorite catch phrase being used in today's media is "The graying of America." There is no denying that current demographic trends reflect the ballooning numbers of older Americans. The Administration on Aging reported in 2006 that elderly people comprise 12.3% of the American population; within the next 30 years, the number of older adults is expected to more than double and will represent nearly one-fifth of the American population (2006). On national, state, and local levels, Americans are beginning to anticipate the implications of this significant population shift. New markets, business opportunities, cultural norms, and social challenges are surfacing in response to the transformation of 'baby' boomers into 'aged' boomers.

Related to the general demographic trends is recognition that housing preferences among older adults change with age, lifestyle choices, and health needs (Krout & Wethington, 2003). Many older men and women in the United States are moving to assisted living facilities (ALFs) as a viable housing option when they encounter physical or psychosocial complications related to aging. An intermediate level of long term care, assisted living represents one among many residential settings that services older adults in the United States. ALFs are noteworthy, however, because they are growing in number

at a rate of 15 to 20 percent annually (Cummings, 2002) and are estimated to be the fastest growing senior housing option of the future (Citro & Hermanson, 1999). According to the National Center for Assisted Living, over one million people live in 28,000 facilities nationwide (2005).

Assisted living facilities (ALFs) evolved in the senior housing market, in part, as a response to the deficits of skilled nursing homes, which struggled to accommodate the needs of all residents and because of a cohort of seniors for whom the high level of care provided by nursing home staff was not required (Chapin & Dobbs-Kepper, 2001). Definitions of ALFs vary; however, some generalizations can be made. The facilities typically (a) create a housing option for elders with a home-like environment, (b) provide assistance with activities of daily living (ADL), and (c) attempt to protect and value autonomy of seniors. The last characteristic hints at a shared philosophy about aging and elders' rights that underlies the assisted living industry. This statement of philosophy, or approach to elder care, often is cited as the point of differentiation between assisted living and other types of residential settings for aging adults. More than nursing homes, which operate out of a medical model granting institutions the power to determine residents' needs and when and how to respond to those needs, assisted living makes an effort to respect resident autonomy (Steinhardt, 1997). In ALFs, an attempt is made to adjust the power relationship so that residents can maintain a sense of control over their immediate environments, including decisions about what services are rendered. Further, ALFs are founded on the belief that it is important for older adults to age in place. Thus, facilities sometimes are part of a larger continuing care retirement community (CCRC) that, in exchange for a fee or endowment paid by the resident, provides a range of care services

from independent living to skilled nursing care so that as residents' health ails, they are ensured housing for the duration of their lives (Central Ohio Area Agency on Aging, 2006; Chapin & Dobbs-Kepper).

Assisted living is a growing part of the senior housing market, and because of its commitment to the philosophies of aging-in-place and resident autonomy, represents an attractive choice among residential care options for elders. However, little is known about the overall psychosocial well-being of ALF residents (Cummings, 2002). In particular, little attention has been paid to the factors associated with a successful transition to communal living in this setting (Krout & Wethington, 2003). Recognizing and understanding these factors is highly important because, "relocation transitions and health crises are among the top 10 life stressors for people of all ages, but are especially stressful for older adults due to their association with loss and ultimately the end of life" (Mead, Eckert, Zimmerman, & Schumacher, 2005, p. 116). This qualitative investigation has invited experts, namely, older adult residents of ALFs, to share their lived experiential knowledge of the developmental transition associated with a residential relocation to the long-term-care facilities known as assisted living.

Statement of the Problem

Almost 10 years ago, assisted living was identified in a report to the United States General Accounting Office (GAO) as one of the top three growth areas in the American business market (Steinhardt, 1997), and the impact of its development has been significant. Even in popular media, such as *Fortune Magazine* and *Assisted Living Executive*, a publication of the Assisted Living Federation of America (ALFA; 2006), the industry has been recognized for its growth potential. Indeed, the ALFA (2006) recently

reported that assisted living has enjoyed an economic boom in 2006 similar to that of the early 1990s, with top providers, such as Summerville Senior Living and Benchmark Assisted Living, expanding their housing capacity by 81% and 65%, respectively. Based on economic trends and popular media recognition, assisted living easily might be considered "the new nursing home." However, research aimed at providing a rich, detailed description of the life of ALF elders and, more specifically, the transition experience related to moving into assisted living, sorely is lacking. Although the industry is booming, examinations into the effects of relocation into an ALF have not corresponded sufficiently to the industry's growth rate.

The literature search for this study has targeted late-life residential relocations and their associated mental health issues and shows strong evidence that the phenomenon of relocation among elders to long term care is not an under-studied area. To provide just a few examples, Johnson, Stone, Altmaier, and Berdhal (1998) investigated the role of self-efficacy on adjustment to nursing homes; Lee, Woo, and Mackenzie (2002) examined the adjustment process for elders who move to nursing homes in China; and Capezuti, Boltz, and Renz (2004) studied Relocation Stress Syndrome (RSS) among nursing home residents. There also exists a large body of quantitative research examining detriments to the mental health of skilled nursing constituents, with depression being among the most frequently examined phenomena, (e.g., Grayson, Lubin, & Van Whitlock, 1995; Gruber-Baldini, Zimmerman, Boustani, Watson, et al., 2005; Scogin, & McElearth, 1994). Additionally, predictors of well-being among residents of nursing home settings have been examined extensively (e.g., Cohen, Hyland, & Devlin, 1999; Karuza, Miller, Lieberman, Ledenyi, Thines, 1992; Reinardy, 1992).

Not surprising, the majority of investigations to date have centered on the nursing home context, which, from the 1960s until the late 1980s and early 1990s, was the only viable option for elders in need of long term care. The few investigations that are relevant to this study in terms of subject matter and context confirm the need for a more in-depth understanding of the significant, sometimes taxing, life-event of relocation to assisted living among older adults. For instance, Cummings and Cockerham's (2004) assessment of predictors of well-being for assisted living residents revealed that ALF elders' well-being is at risk to be affected negatively by the relocation process, with ailing health and diminishing social relationships tending to predict depressive symptoms. Likewise, in an investigation into non-dementia elders' perceptions of residential relocation to assisted living, Kampfe (2002) concluded that most residents perceived the move to an ALF to be significant; at least half of the participants perceived the relocation as stressful and disruptive, and a little more than a third felt both "bad" and "good" about the quality of life provided in the ALF.

Even with the advances that the current body of scholarship provides in terms of general understanding about residents of long term care, it does not shed light adequately on the multifaceted and rich transitional experience that elders face when they relocate to assisted living sites. The serious lack of information about this transitional phenomenon and the corresponding need for a greater understanding of ALF elders' experiences is clearly evident, especially in Ohio, where this investigation has taken place.

In May, 2003, Mehdizadeh and Applebaum filed a report funded by the Ohio Department of Aging and the Ohio Legislature in which they noted that, "Over the past ten years, the state has experienced a continued shift in the way older Ohioans receive

long term care. More older people are receiving long term care in their own homes and in assisted living facilities" (2003, p. i). Since 2001, nursing homes in Ohio have been used more on a short-term than a long-term basis, with residents tending to stay not more than three months after transferring there from a hospital and then returning to the community (Mehdizadeh & Applebaum). Moreover, the overall occupancy of nursing homes in Ohio has declined in the past 10 years. Two of the main reasons for the decline in nursing home use are the "expansion of long-term care options, including in-home services through Ohio's PASSORT program and the development of the assisted living industry…" (Mehdizadeh & Applebaum, 2003, p.10). The closest estimates indicate that there are over 500 residential care facilities in Ohio (Ohio Assisted Living Association, 2006) and, that between the years 1993 and 1999, the number of new beds at these types of sites had grown by 210% (Mehdizadeh & Applebaum). With Ohio's assisted living industry assuming a prominent place as a permanent, senior residential care option for elders, it is clear that researchers need to pay attention to the psychosocial implications of the transition into ALFs.

Finally, assisted living is distinguished from the nursing home industry in terms of the environmental design of its facilities, the limited level of skilled nursing care it is permitted to provide, the philosophical approach to senior residential care that it espouses, and the licensing regulations to which this housing domain must adhere. Especially in Ohio, where a state-wide environment undoubtedly has been supporting the growth of assisted living to the decline of skilled nursing home care as the senior residential care option of choice, it seems wise also to produce unique research products for each type of care facility and not to assume that the transition experience and

subsequent adjustment process is the same for older adults who move to nursing homes and those who relocate to assisted living facilities.

Neither quantitative nor qualitative research has explored adequately the key development issues associated with the relocation from home residences to assisted living. Thus, pressing questions about the transition remain: How does the transition to assisted living have an impact on an older adult's development? How do older adults experience the complexity of losses that surround residential relocation to ALFs? What meaning do older adults attach to a late-life relocation to an ALF? In what ways might the staff in assisted living facilities contribute to a satisfactory transition? What are the most effective interventions in helping residents through the adjustment process? What resiliencies do older adults possess that act as resources in the transition period? Answering these and other similar questions can provide a base-line understanding of the experiences associated with the move to assisted living. A qualitative, phenomenological investigation such as the one that has been conducted in this study has been well-suited to use these and other questions to explore the ecological transition experienced by older adults who relocate from a home residence to an assisted living facility.

Significance of the Study

Investigations into the mental health issues of elders residing in assisted living facilities indicate that, while many residents make healthy adjustments to these controlled community environments, a "sizable proportion of elderly people suffer from impaired psychological well-being" (Cummings, 2002, p. 299). In her study, Cummings issued a call for further research into "factors affecting ALF resident well-being" (p. 300). Her efforts to identify factors that seem to promote well-being suggest that social support,

assistance with activities of daily living, and elders' perceptions of the type and level of social support received all are important.

This current investigation is significant, in part, because it has been an attempt to respond to Cummings' (2002) recognition that more information is needed about the factors that aid elders in their transition to ALFs. To say that "social support" is a protective factor against psychosocial impairment is only the first step in understanding the transitional experience. Defining the nuances—the specific aspects of social and intrapersonal support that are valued by elders—are some of the goals of this study that have given it significance. By providing an opportunity for residents of ALFs to describe their lived experiences and to share their reflections about the physical, social, relational, spiritual, and psychological factors related to the transition to identified facilities, this study has created a richer and more in-depth understanding of the meaning of the relocation to ALFs and has concerned itself with identifying some of the barriers and the supportive factors that are present in this phenomenon. Such understanding contributes to the increased ability of helping professionals, such as counselors, to prepare older adults who leave their home residences for assisted living facilities and to better meet the needs of adults already living in ALFs.

Additionally, this inquiry is significant because of its ability to generate new hypotheses about the transition experience to assisted living, as well as raise informed questions for future research. Qualitative investigations are often useful for gaining deeper understandings of under-studied phenomenon, such as the late-life transition to assisted living, and for identifying threads of research that demand further attention. This investigation has provided new hypotheses about elders' lived experiences of transition to

assisted living and about broader, cultural influences that precipitate the transition. Finally, the inquiry has provided various new questions for research that are of interest to professional counselors, including but not limited to: (a) How do value systems among older, ethnic minority populations influence the ways they utilize assisted living as a health care option? (b) To what extent is an autonomy supportive environment related to elders' ability to engage in a normal developmental trajectory when they transition into an assisted living facility? (c) In what ways can elders, staff, and administrators in assisted living facilities enhance opportunities for meaningful, social interactions that can be maintained over time? (d) What support systems are available to residents in their grieving processes when they are faced with the deaths of community members and friends and how changes, adjustments, and additions to existing systems could help residents manage the loss of significant relationships?

Rationale

The rationale for this investigation hinges on three realities: older adults are currently underserved by mental health professionals; a significant gap exists in the literature with regard to understanding the phenomenon of the ecological transition to assisted living; and appropriate interventions that fit the needs of older adults who relocate to ALFs are lacking. First, as part of the aging population of Americans, ALF elders already are underserved considerably by mental health and counseling services (Myers & Harper, 2004; Myers & Schwiebert, 1996). Elderly people currently receive only 2 % of private mental health services (Robb, Chen, & Haley, 2002; Swett & Bishop, 2003) and 6-8% of community mental health services (Myers & Harper). Shifting demographics towards increasing numbers of elderly citizens and research indicating

existing mental health concerns in this group suggest that professional counselors be alert to gerontological issues (Myers & Harper). Attending to and understanding the psychosocial needs and developmental tasks that arise during the transition to assisted living facilities is critical because, "the most stressful and painful conflicts [for older adults] occur when a decision regarding where to live, especially a decision possibly involving institutionalization, seems inevitable" (Miller, as cited in Myers, 1988, p. 333).

Second, the growing industry of assisted living and its cohort of residents have attracted the attention of gerontologists, medical professionals, social workers, and, to a lesser degree, counseling professionals, who have begun to look at the complexity of issues that surrounds residential relocation to ALFs. Research (Loeher, Bank, MacNeill, & Lichtenberg, 2004) indicates that, indeed, a significant percentage of adults who perceive negatively the transition to *nursing homes* face serious mental health issues. However, the voices of older adults who relocate to *assisted living facilities* are missing from the literature. An important reason for conducting this study, therefore, has been to allow for greater insight into the transition associated with the relocation to an assisted living facility by seriously studying the experiences of residents of ALFs.

Finally, insights that have been gained from this investigation contribute to the development of interventions that most appropriately fit ALF elders' needs and add to their quality of life as long-term-care (LTC) residents and consumers. Some would be satisfied with long term care that protects elders and operates from the position that when health and safety standards are met, adequate care is provided. However, Kane (2001) raised an important question when she asked if safety is the "be-all and end-all" (p. 296) of long term care. A higher aspiration towards which LTC providers, social workers,

professional counselors, and policy makers might aspire on behalf of older adults is ensuring safety and health standards within the framework of *quality of life*.

Conceptual Assumptions

van Manen (1997) suggested of phenomenological research that, "the problem…is not always that we know too little about the phenomenon we wish to investigate, but that we know too much" (p. 46). With this statement, he introduced the important topic of addressing or "bracketing" assumptions, preconceived notions, and common sense understandings of the research topic prior to beginning an active investigation. In this piece of research, there are several assumptions that must be acknowledged about the theoretical orientation as well as about the transition experience itself.

The first assumption—related to the theoretical foundation of this study—is that development is a lifelong, contextually bound endeavor. An ecological perspective on human development contends that development is "always embedded and expressed through behavior in a particular environmental context" (Bronfenbrenner, 1979, p. 27). Moreover, Bronfenbrenner suggested that ecological transitions, both instigators and consequences of development, happen throughout the lifespan. The implications of the assumptions about development for this study, therefore, are that (a) older adults are actively developing; (b) development or adjustment to the transition experience is the result of more than just psychological factors; and (c) the transition to an assisted living facility provides an opportunity for transformation, growth, and development.

Another presupposition that needs to be recognized is that the transition to long term care is always detrimental to older adults. Although a large set of findings abounds

with regard to the risks to psychological well-being (e.g., increased threat of depressive symptomatology) relative to living in both nursing homes and, to some extent, assisted living facilities, negative outcomes are not absolute. Therefore, this researcher acknowledges—and has been sensitive to—the reality of successful transitions and positive developmental changes related to older adults' relocation to an assisted living facility.

Research Question

The main research question that has been proposed in this study is: How do older adults experience the late-stage, life-span transition when they permanently relocate from a home residence to an assisted living facility? Literature from various perspectives on adult aging and development has informed this question. Demographically, the population of older adults rapidly is increasing; culturally, ALFs have emerged in the United States as the long term senior care option of choice; philosophically, ALFs fill a need for an approach to senior care that protects elders' autonomy and dignity; psychologically, older adults, especially those in long term care, are underserved by mental health professionals; and investigatively, the experiences of older adults who move into assisted living have been overlooked. These broad considerations confirm the critical nature of qualitatively examining the transition to ALFs by responding to the research questions of interest. To answer the research question, a number of protocol questions have been posed; they are presented in Chapter 3.

Definition of Terms

There are a number of concepts that need to be defined for the purposes of this inquiry. These include: assisted living facility, ecological transition, development, home

residents, and older adults. The meanings of these concepts in this investigation are provided below:

Assisted Living Facility: a senior housing option and intermediate level of long term care that typically is designed to: (a) provide a home-like environment, (b) assist residents with activities of daily living, and (c) protect and value autonomy of seniors.

Ecological Transition: experiences that "occur whenever a person's position in the ecological environment is altered as the result of a change in role, setting, or both" (Bronfenbrenner, 1979, p. 26).

Development: "the phenomenon of continuity and change in the biopsychological characteristics of human beings both as individuals and as groups. The phenomenon extends over the life course across successive generations and through historical time, both past and present" (Bronfenbrenner, 2005, p. 3).

Home Residence: the permanent living environment—either a home or apartment—in which a person has resides and at which a person maintains a high degree of autonomy.

Older Adults: men or women who are over the age of 65.

Delimitations of the Study

The parameters of this study help to define and provide rationale for the decisions made about the setting and participants of the research inquiry. This study is interested singularly in the facilities defined by Ohio regulation #3701-17-50 (Ohio Department of Health, 2006) as "residential care facilities" and popularly known as assisted living facilities. Until now, conclusions about the lived experience of residents of ALFs only can be inferred from a limited number of quantitative studies conducted in ALFs, from

examinations involving nursing home residents, or, as van Manen (1997) noted, from assumptions, presuppositions, or common sense.

According to Ohio regulations, licensed residential care facilities are permitted to provide (a) accommodations, (b) personal care services, or help with activities of daily living, such as bathing, dressing, grooming, and receiving medications, and (c) up to 120 days of nursing services, usually granted on a part-time basis (Encyclopedia of Everyday Law, 2006). Nursing homes, on the other hand, are licensed to provide full-time nursing and personal care services, and many older adults choose such settings because of a corresponding need for greater levels of intervention. A national study by Hawes, Philips, and Rose (1999) validated the differences in impairment among nursing home and assisted living residents. The researchers found, for instance, that many ALFs would not admit persons who needed regular assistance transferring out of bed or a chair, nor would they admit persons who were found to have moderate to severe cognitive impairment.

The impact of relocation to an ALF may be of great significance to residents who potentially are at an "in-between" moment of development. Unlike many residents of nursing homes who require higher levels of care, residents of assisted living usually are aware of their need for help but are not fully reliant on others for assistance. Limiting the study to ALF sites and ALF residents thus has allowed me to capture this "in-between" moment of the developmental process by looking at the transition to an ALF more so than if nursing home sites and nursing home residents had been included.

Participant Parameters

Assisted living sites are the preferred context for this investigation. A more specific description about the decisions that have been made relative to the study's delimitations surrounding individual participants follows.

Age.

First, in order to comply with the operational definition of "older adults" that has been created for this study, participants are aged 65 years and older. The term "older adults" commonly is used to refer to persons aged 65 and above, by such organizations as The Administration on Aging (AoA; 2006).

Length of stay in the facility.

Second, residents must have lived in the facility for more than two months. The rationale for this decision is based, first, on van Manen's (1997) discussion of lived experience research as tapping into co-researchers' consciousness, reflections, and recollections. He suggested that, "A person cannot reflect on lived experience while living through it…thus, phenomenological reflection is not introspective but retrospective. Reflection on lived experience is always recollective; it is reflection on experience that is already passed or lived through" (p. 10). Allowing at least some time to pass before conducting participant interviews has seemed important for the reflection process. The decision also is based on research findings and methodological precedents set by inquiries related to adjustment processes to long term care. Although little is known about the adjustment period to assisted living, studies on relocation and relocation trauma (i.e., stress and consequent symptoms of stress that are related to residential relocation) within other health care environments, such as hospitals, have suggested that

acute symptoms related to transitions in these settings were resolved within 6 months (Farhall, Trauer, Newton, & Cheung, 2003). Based on these findings, I could have decided only to invite residents who lived *at least* 6 months in a facility in order to provide optimal safeguards to the psychological health of participants.

However, precedents in research design suggested that data collection with transitioned elders can begin almost immediately upon the relocation experience without presenting psychological risks to participants. Lee, Woo, and Mackenzie (2002), who conducted a qualitative examination of the adjustment process to a nursing home, began their data collection within one week of residents' relocation. Wilson (1997) began data collection within 24 hours of residents' placement and Brooke (1989) made contact with residents before they had lived 2 months in their long-term-care sites. Researchers, thus, have begun data collection within as little as 24 hours from the time of the relocation without evidence of causing harm to participants.

In keeping with the phenomenological framework that has informed this study, it has been important that, when at all possible, elders have not been in the midst of living through the immediate transition experience. Although methodological precedents suggest that data collection can begin almost immediately after relocation to long-term-care sites without posing a threat to participants, in this study it has been important to invite elders who are not faced with the immediate adjustment issues likely to be present in the first several weeks of relocation. This decision increases the chances that participants will have had an opportunity to reflect on the meaning of the transition from their home to an ALF and, just as important, decreases the likelihood that they would encounter undue stress as a result of participating in the study.

Home as the primary residence before the transition.

Third, residents must have transitioned to the facility from a home residence and not another type of facility (e.g., nursing home). Mehdizadeh and Applebaum's (2003) research has shown that 80% of older Ohioans who do spend time in a nursing facility typically return to the community within three months. Targeting elders who transition to assisted living facilities from their home residences has helped capture the most common experience of older adults. Also, it seems likely that the transition from a home residence to an assisted living facility requires more immediate and greater coping mechanisms than does relocation from another type of facility, in that elders who move to ALFs from other residential care sites already will have had an opportunity to adjust to the loss of their homes, possessions, and, perhaps, their independence. Finally, the concept of a transition from home is at the heart of this study. Elders leaving their *homes* is an existentially important experience. van Manen (1997) described home as the place "where we can *be* what *we are*" (p. 102) and noted that "the home reserves a very special space experience which has something to do with the fundamental sense of our being" (p. 102). What, then, must elders think and feel when they either are removed from or decide to leave their homes at a point in their lives when the reality of death—a final home-leaving—is likely to be close at hand? Indeed, for many elders, the idea of dying at home is one that they may have taken for granted, which, again, suggests the importance of the lived space called home. Thus, to capture the essence of this relocation experience it has been important that elders in this study have transitioned from their homes to the "home-like" environments of assisted living.

Cognitive awareness.

Fourth, residents must not have resided in an Alzheimer's unit or building and must have shown a level of cognitive readiness that allows them fully to engage in the focus group or interview process as indicated by the researcher's clinical assessment or by the results of the Mini Mental Status Exam (MMSE, Crum, Anthony, Bassett, & Folstein, 1993; Folstein, Folstein, & McHugh., 1975). The MMSE has been used as one tool to evaluate participants' cognitive awareness, which is important to their ability to understand and reflect meaningfully upon their transition experience.

Gender.

Finally, co-researchers who have been invited to participate in the study both are male and female residents of assisted living facilities. Opening the study to older men and older women gives a rich and varied description of transitions and allows me to get at any potential nuances related to gender. Interviewing men especially will be important because assisted living facilities traditionally have housed greater numbers of men than women.

Facility Parameters

Setting parameters around the individuals who have been invited to participate in this study has unfolded in a fairly straightforward process; making decisions about which facilities to involve, however, has been a more difficult and daunting task. The nationwide assisted living industry is marked by variability which seems to be reflective of the lack of federal regulations that guide this sector of senior residential care. Ohio's assisted living market mimics the national trend in variability (Utz, 1999), and its more than 500 facilities (Ohio Assisted Living Association, 2006) differ with regard to

numerous characteristics. Examining the differences in these characteristics has been part of the process of delimiting which facilities are asked to be involved in this study.

Another important part of the process of setting facility parameters has involved identifying guiding principles that could be used to make decisions. To identify these guidelines, the following question has been considered: "What factors associated with facilities potentially can affect the transition process that is of central interest to this study?" Reflecting on the literature related to Ohio's assisted living industry and on research about transition or adjustment to ALFs has led me to identify two key principles for setting limits about the ALFs in this study.

Quality of care.

The first guideline that has been used to evaluate facilities is related to the quality of care provided by the ALF. Kampfe (2002) noted that elders who have a positive perception of the quality of their relocation to assisted living and of the facility itself use less maladaptive coping mechanisms in response to their move. Providing the best opportunity to tap into the experiences of elders who have the fewest roadblocks to a healthy transition is important to understanding what successful transitions look like.

To refine or operationalize the guideline related to quality of care, I have used information related to licensure and consumer complaints filed against facilities. First, all facilities in this investigation are licensed by the Ohio Department of Health, according to residential care facility guidelines; none of the facilities have breeched the licensure regulations in ways that the department of health considered as posing real and present danger to the residents. All facilities meet, or nearly meet, the statewide average on compliance with licensure regulations. By restricting the search of facilities to those that

are licensed and that have high degrees of compliance with regulations, I have attempted to capture a sample of sites that *at least* adheres to minimum state requirements. It seems logical to assume that licensure and compliance are the first steps in providing the best quality of care for residents. Additionally, it seems reasonable to believe that managers of licensed facilities (more than those in unlicensed facilities) aspire to service their clientele with greater than minimal levels of care. Second, facilities that have had substantiated consumer complaints lodged against them have been excluded from the study. Information about facility compliance to licensure regulation and consumer complaints has been retrieved online from the State of Ohio Long Term Care Consumer Guide to residential care facilities.

Variability in facility type.

The second guiding principle that has been used to set parameters for facilities relates to variability. Literature about the national assisted living market and the Ohio market (Utz, 1999) repeatedly has reported that variability is an industry trademark. Therefore, the approach of this study is that the delimitations should not fight industry variability, but rather, should allow for it in order to be able to make statements about the role of environmental differences in the transition process.

To substantiate this decision, and to clarify what is meant by "variability," it is helpful to look at some of the characteristics of Ohio ALFs that Utz (1999) compiled. Utz found that differences such as facility size, profit status (i.e., for-profit or not-for-profit), cost, and management licensure (i.e., whether or not facility managers were licensed nursing home administrators) had no effect on resident characteristics. Therefore, I have

assumed that targeting facilities based on these factors do not make a difference in terms of the type of residents that they house.

Utz did find, however, that the type of facility (i.e., free-standing, assisted living as part of a continuing care retirement community (CCRC), assisted living with independent living, and assisted living with a nursing home) had a significant impact on the residents' cognitive impairment. Assisted living facilities with independent living components appeared to house the least cognitively impaired adults and were the most cost effective. Moreover, free-standing facilities and those within a CCRC housed residents who needed the most help with activities of daily living. Together, these findings seemed to suggest that assisted living sites with an independent living component may be the most useful in recruitment of participants, because they appear to house the least cognitively impaired individuals. Demographically, however, assisted living with an independent living component comprises only 15% of Ohio's ALFs, while free-standing sites comprise 46% and CRCCs comprise 23%.

To summarize, the facilities that have been chosen to fit the parameters of this study reflect two guiding principles: (a) facilities meet quality of care standards as determined by licensure status and compliance and lack of consumer complaints, and (b) facilities represent the variability inherent in the ALF market. Although assisted living sites with independent living components may house more cognitively ready adults, other types of facilities that make up a considerable proportion of the ALF market in Ohio have not be excluded.

Summary of the Inquiry

This inquiry has been concerned with learning about the lived experience of a late-life relocation from a home residence to assisted living. The opening chapter has provided a description of the nature and importance of the investigation and has introduced the theoretical and methodological foundations of the study. Chapter 2 is dedicated more fully to constructing the theoretical framework that has supported and informed the inquiry, and in large part, focuses on the bioecological and motivational underpinnings of the study. Key features of the assisted living industry also are described, and the literature related to late-life transitions is presented. Chapter 3 focuses on the methodological structure and design of this piece of qualitative research and provides an explanation of how data were collected and analyzed.

In Chapter 4, the findings of the inquiry are presented through written descriptions of the co-researchers' lived experiences. Detailed analysis of the focus group and individual interview findings are noted, and emergent themes of the participants' experiences are identified. Finally, Chapter 5 discusses the major findings of the inquiry. In Chapter 5, broad conclusions are drawn, based on the specifics of participants' experiences, and implications of the study are noted. Additionally, attention is paid to the "negative space," or areas left untouched and undescribed by the investigation, and what these areas suggest for further research.

CHAPTER II

REVIEW OF LITERATURE

There are three goals of this literature review. The first aim is to introduce the theoretical framework of this investigation into the late-stage, life-span transition to assisted living. The second goal is to provide a concise overview of literature that highlights the key issues related to late-life residential relocations. The final aim is to describe the assisted living industry, both nationally and in Ohio, the context of interest for this study.

Theoretical Backdrop: Framing Residential Relocation

Not only was it difficult to limit the theoretical scaffold of this study to one approach to understanding a lived human experience, but it also seemed imprudent to do so. This investigation focused on illuminating the experiences of older adults who move from what was assumed to be an at least somewhat autonomous existence in their homes into the relatively controlled environments known as assisted living. Because the impact of this transition seemed likely to be multifaceted, with effects appearing on social, relational, psychological, spiritual, and physical levels, limiting the theoretical backdrop of this investigation to a single psychological or sociological approach to adult development and aging would not have provided the depth or breadth of understanding needed to shed light sufficiently on the experiences of the participants. At the same time, it seemed important to create a theoretical structure that was not fragmented by an attempt to account for all models and that found strength in one or two primary approaches to interpreting the shared reflections of older men and women who undertake the residential relocation to assisted living. Two guiding theories, therefore, were used in

this investigation—a bio-ecological model of human development (Bronfenbrenner, 1979, 2005) and self-determination theory (SDT; Ryan & Deci, 2000; 2006). Before addressing these two theories, however, this section briefly will summarize a number of psychological and sociological theories of adult development and aging that often have been utilized in examinations involving older men and women. Because of their prominence in scholarship related to adult development, some of these approaches deserve mention.

Psychological Theories of Personality Development and Aging

Erikson (1959) provided a stage-theory of development that centers on eight crises the individual must resolve for successful personality development. The eighth and final stage—integrity versus despair— frequently has been used as a variable of investigation or as a theoretical backdrop in studies involving older persons. The task of the eighth stage involves looking back over one's life to identify meaningful moments and an overall sense of worth and contribution to society, family, and self. During the process of responding to this crisis, some individuals form a more positive view of themselves and their lives than others, who have to deal with feelings of bitterness or disappointment during their life review (Hoyer & Roodin, 2003). Erikson's suggestion that the last, important struggle in the life cycle involves a rather summative meaning-making process holds pragmatic value for studies focused on older adults.

Sociological Theories of Aging

A number of theoretical approaches to aging and adult development have emerged in the sociological discipline. One of the earliest sociological models is engagement theory, which suggests that older adults and others in their environment

engage in an inevitable, universal, and mutual withdrawal from each other (Cumming & Henry, 1961). The theory proposes that as men and women get older, it is normal for them to disengage willingly from their social roles and to have less desire to be involved in their earlier pursuits. Another approach, role theory, conceptualizes the aging process as a transformation in lived roles, such as "working adult" to "retired adult" (Cottrell, 1942). A third model, which tends to be empirically discredited today, but which still holds value for many older adults, is activity theory (Lemon, Bengtson & Petersen, 1972). Activity theory is grounded in the assumption that optimal development for the aging individual is positively related to staying active and resisting withdrawal from the environment and social relationships. Finally, continuity theory (Atchley, 1972) purports that the healthiest late-life developmental pattern is one in which adults continue their midlife behaviors, interests, and activities into late adulthood.

Bio-ecological Model of Human Development

Each of the psychological and sociological theories described above provides a useful set of concepts by which to understand the phenomenon of interest in this examination, and they are considered important in evolutionary thinking about aging and adult development. Yet, on their own, each of these approaches was considered "necessary, but insufficient" (L. Lopez Levers, personal communication, February 13, 2006) to describe the multi-dimensional and multi-directional nature of human development. The psychological approach to development is limited by its pinpoint focus on the individual; the sociological approaches, while accounting for shifts in the activities, patterns, roles, and relationships of individuals, only provides a "limited understanding" (Jacobson & Wilhite, 1999) of the influences on the aging person and do

not fully appreciate the personal, internal processes that have an impact on development. Therefore, an ecological framework that accounts for a diversity of individual *and* environmental factors was preferred. Specifically, this study was cast foremost against Bronfenbrenner's (1979; 2005) bio-ecological theory of human development.

In his early writings, Bronfenbrenner (1979) conceptualized development as "a lasting change in the way in which a person perceives and deals with his environment" (p. 3). Later, he expanded and refined this definition to refer to the "phenomenon of continuity and change in the biopsychological characteristics of human beings both as individuals and as groups. The phenomenon extends over the life course across successive generations and through historical time, both past and present" (2005, p. 3). In his latest writings, Bronfenbrenner summarized his theory in a number of propositions that characterize the most lasting or timeless elements of the bio-ecological model.

Perception and subjective interpretation.

One proposition that is of particular relevance to this study on late-life transitions suggests that human experience is fundamental to development. As people undergo the process of change, they are responding to the objective environment as well as to their phenomenological interpretations (i.e., perceptions) and subjective, emotional experiences of the environment. Both the objective and the subjective elements are equally influential and interact with one another in the course of human development (Bronfenbrenner, 2005).

The influence of perception on human development that Bronfenbrenner (2005) noted also has been studied by numerous scholars (e.g., Pearlin, 1991; Ross & Altmaier, 1994; Ryff & Essex, 1992; Wheeler, 1996) who examined the role of perception on

transition outcomes; Kampfe (2002) looked at the particular phenomenon of elders' perceptions to the late-life transition inherent in residential relocation. The results of her study pointed toward the subjective nature of perception, and she concluded that while "[c]ounselors can expect trends in the ways people perceive residential relocation, …counselors cannot assume that all their clients will perceive their moves in the same ways" (p. 110). Moreover, Kampfe emphasized the usefulness of considering persons' subjective interpretations of events and noted that "[b]ecause perceptions have the potential to influence the responses and outcomes of events, it is important for counselors to determine their clients' perceptions of their moves" (p. 110). Together, Bronfenbrenner's emphasis on perception as a driving force in human development and Kampfe's research on elders' perceptions of late-life relocations to ALFs have suggested that biopsychological changes in older adults who undergo a late-stage transition occur on a intrapersonal level and are related to the way that elders perceive the objective, ecological transition at a point late in their life course.

Proximal processes.

Human development involves a subjective, perceptual component; additionally, Bronfenbrenner (2005) defined development in terms of the influences of overt, objective, environmental changes. To describe the power of the external environment on development, the bio-ecological model refers to proximal processes, or interactions that must occur consistently between a person and other people, objects, or symbols in the immediate environment (Bronfenbrenner). Many of the examples to which Bronfenbrenner referred in his description of proximal processes relate to childhood and adolescent development, when the time for change, skill-building, physical growth, and

intellectual advancement is rich. However, some literature related to aging and adult development also has supported Bronfenbrenner's conceptualization of proximal processes for the older population. Cummings (2002), for instance, examined the well-being of an older population residing in an assisted living facility. Over half of the population in this study regularly received help with their activities of daily living. Cummings found that residents who had the fewest numbers of depressive symptoms, or whose well-being seemed most supported, were residents who not only received help with the daily activities of living, but who also had social supports in the immediate environment. Specifically, Cummings suggested that quality relationships improved older adults' chances of positively responding to permanent relocation to the assisted living context. Thus, the idea of regular environmental supports or interactions that Bronfenbrenner identified as key to development appears to be relevant for a population of older adult residents in assisted living.

While emphasizing the power of proximal processes on development, Bronfenbrenner (2005) also saw the environment as consisting not only of close relationships, but also of systems that lie seemingly beyond an individual's sphere of influence. In all, Bronfenbrenner described four spheres or environmental systems, nested one inside the other, and labeled, from the inner-most to the outer-most system, as the microsystem (the immediate family environment), mesosystem (shifts from one microsystem to another), exosystem (the socio-political system), and macrosystem (a society's attitude's and ideologies). The individual, with his or her own psychological, cognitive, physical, and spiritual characteristics is situated inside the microsystem.

Ecological transition.

In interaction with immediate and distant environmental factors, individuals frequently experience ecological transitions or experiences that "occur whenever a person's position in the ecological environment is altered as the result of a change in role, setting, or both" (Bronfenbrenner, 1979, p. 26). Ecological transitions, which are both instigators and consequences of development, are considered to be part of the mesosystem; they include shifts from one microsystem to another, such as going to daycare, leaving home for college, retiring, or, as in the case of this study, relocating from a home to an assisted living facility. Residential relocation is a clear example of a change in setting and in role that, from an ecological perspective, has an impact on the individual adult's development. As Bronfenbrenner stated, "each…transition has developmental consequences that involve the person in new activities and types of social structure" (2005, p. 46).

Since the relatively new emergence of assisted living to the senior housing arena in the mid 1980s (Utz, 1999), little, in-depth, descriptive research has been conducted into the key developmental issues at play for older adults during a mesosystemic, ecological transition to an ALF. Therefore, to create a richer context for this investigation, it was helpful to step back and look not only at what was known already about consumers of long term care (LTC) in the United States, but also at some of the broader social, cultural, and legislative issues related to aging and the long-term-care industry.

Macrosystemic issues: Aging in American society.

From an ecological perspective, a person's development is shaped most by forces within the microsystem (e.g., encounters with family, peers, neighborhoods, and religious entities) but is affected, nonetheless, by broader systemic influences on a "macro" level, such as a society's attitudes and ideologies. The prevalence of myths and stereotypes in American culture related to aging and older adulthood hints at this society's underlying attitudes and beliefs about the aged. Older adults are often typecast as senile, incompetent, rigid, emotionally fragile, and asexual (Ediberg, 1988). Thus, it becomes easy to imagine many decision-making processes (not only those surrounding the transition to long term care) in which older adults are discounted or subtly shunned by younger relatives who operate from a stereotypical belief system about aged adults.

The connection between macro-level attitudes and ecological transitions to long-term care is an important and highly researched area. Most often the connection has been examined in studies that look at the relationship between "locus of control" and psychological well-being. Rotter (as cited in Johnson, Stone, Altmaier, & Berdahl, 1998) described the concept, locus of control, as "the degree to which individuals believe they have control over the environment" (p. 209). In studying the influence of self-efficacy and locus of control on adjustment for nursing home residents, Johnson et al. concluded that individuals with a perception of competence and sense of control correlated to more positive affect. Although Johnson and colleagues did not directly address the attitudes or ideologies at play in the decision making process surrounding the transition to a nursing home, it is easy to imagine how external influences such as stereotypes or myths about older adults' impaired cognitive ability, incompetence, or emotional fragility can shift the

locus of control away from elders and potentially have a negative affect on well-being. In a lived experience examination such as the one conducted in this study, it seemed important, therefore, to be sensitive to the implications of cultural myths and stereotypes on the transition experience to assisted living.

Exosystemic issues: National and state initiatives on aging.

Another indirect, though still very influential aspect of the developmental sphere, is what Bronfenbrenner (1979) labeled the exosystem. The exosystem represents the social system, political climate, and public policy initiatives backed by the local, regional, or national governments under which people live. In the United States, the federal government has recognized and responded to the needs of older adults in a variety of forums over the years. For example, in December, 2005, the fifth White House Conference on Aging since the 1950s convened to discuss and vote on issues related to aging and older Americans, as well as formulate recommendations for future research and policy action. Previous conferences have supported the creation of programs such as Medicare, Medicaid, Older Americans Act, Social Security reform, and the development of the National Institute on Aging. The 2005 delegation, with a mandate to pay special attention to the needs of current seniors and future needs of baby boomers, was asked to vote on the top 50 initiatives and to "develop implementation strategies that they believe are the most important for current and future generations of seniors" (White House Conference on Aging, 2006). Among the 50 most important resolutions that have implications for this study are: (a) fostering innovations in financing long-term-care services to increase options available to consumers (b) applying evidence-based research to the delivery of health and social services where appropriate, (c) enhancing the

availability of housing for older Americans, (d) enhancing the affordability of housing for older Americans, and (e) improving recognition, assessment, and treatment of mental illness and depression among older Americans.

The role of the federal government in directing and regulating the assisted living industry traditionally has been minimal. In a 1997 report to the United States General Accounting Office (GAO) on issues of quality-of-care and consumer protection in assisted living, Steinhardt identified several federal offices (e.g., Health Care Financing Administration, Social Security Administration, Administration on Aging, Food and Drug Administration, Department of Housing and Urban Development, Department of Justice, and Federal Trade Commission) that bear some responsibility for overseeing the protection of ALF residents' rights. However, she also noted that states largely are accountable for managing policy and regulatory issues, developing licensing standards, and monitoring care related to the assisted living segment of senior housing (Steinhardt).

State regulations on assisted living typically deal with three areas: (a) the living accommodations provided on-site, (b) policies on admission and retention of residents, and (c) services rendered on behalf of residents by the facilities (Steinhardt, 1997). Moreover, states vary with respect to the models they use to develop licensing standards and regulations for ALFs. Some states apply existing standards for the residential care option known as "board and care" to the regulation and licensure of their assisted living facilities. (Ohio, the milieu for this investigation, uses existing standards for "residential care facilities" to license assisted living facilities.) Steinhardt (1997) noted of board and care homes that "our past reports and those by others have found enforcement of standards to be weak and authorized sanctions to be infrequent" (p.7). Moreover, she

stated that some AARP reports "found the board and care home industry to have numerous quality problems, such as residents suffering from dehydration or denied adequate medical care" (Steinhardt, 1997, p. 7). The incidence of similar problems in assisted living facilities that fall under the same regulations is not known. Although the main goal of this investigation was not to evaluate the quality of care that elders receive in ALFs, nonetheless, it seemed important to be aware of potential discrepancies between what elders expect to receive in terms of health care services from their facilities and the day-to-day reality of the quality of such services, because of the impact that these discrepancies can have on the adjustment process (Kampfe, 2002) and more importantly, on consumers' physical health and well-being.

Microsystemic issues: Psychological issues in long term care.

Of more immediate concern to ALF elders are microsystemic issues such as risks and protective factors surrounding the well-being of residents of institutional care settings. There is a long history of investigations into psychological risks for residents of long term care; among the most studied constructs is depression. Depression is considered a prevalent and serious mental health issue facing elderly individuals (Serrano, Latorre, Gatz, & Montanes, 2004). According to Nussbaum (1998), depression was reported in 2-8% of older adults living in the community. Depression among residents of long-term care facilities is of even greater concern. In health care settings, the rate of depression increases to 10% for persons in a primary health care setting and 15% for adults in acute care or nursing homes (Nussbaum). Although the number of studies conducted with assisted living facility residents is minimal, initial research suggests that older adults in ALFs have a higher incidence of depressive symptomatology than do

community dwelling adults (Grayson et al., 1995; Lawton, Parmelee, Katz & Nesselroade, 1996). The most recent statistics indicate that assisted living residents are three times more likely to develop clinically significant depressive symptoms than elders living in the community (Cuijpers & van Lammeren, 1999). These statistics are striking because depression in institutionalized settings is "often chronic, undiagnosed, linked with decreased functioning, and inappropriately treated" (Llewellyn-Jones, as cited in Cummings & Cockerham, 2004, p. 28).

Historically, research has demonstrated a relationship between functionality and the levels of social support that elders experience and the depressive symptomatology they exhibit. To study predictors of depression in ALF residents further, Cummings and Cockerham (2004) examined the impact of social support and health on life satisfaction and depression in assisted living residents. They reported that a significant subpopulation of ALF elders had impaired psychological well-being related to elevated levels of depressive symptoms and low levels of life satisfaction. Predictors of poor psychological health included decreased physical functioning as well as a lack of perceived social support. Cummings and Cockerham further noted that perceived social support and satisfaction with both social contacts and the surroundings were indicators of psychological health and might even prevent depression.

Summary.

Conclusions that can be drawn from this brief section of the literature review include the following: (a) cultural myths and stereotypes about the elderly that potentially can limit their autonomy may be an important factor in understanding how successful or unsuccessful transitions to ALFs occur; (b) national initiatives recognize the urgent need

for research into aging issues, including issues of housing and mental health; (c) the lack of federal regulations and minimal state regulations for assisted living are reason to be attentive to the issues of quality of care in relation to older adults' transition experiences into ALFs; and (d) the psychological well-being of assisted living residents is at significantly greater risk than that of community dwelling older adults and, thus, warrants a more detailed investigation into the protective factors and barriers associated with successful transitions to ALFs. Additionally, the quantitatively oriented research presented to this point yields important and broad generalizations about elders and long term care, but does not get at the "lived experience" of residents of assisted living facilities or contribute to a rich description of the meaning of life in long term care that were the aims of this study.

Self-Determination Theory: A Supplemental Approach

The bio-ecological model (Bronfenbrenner, 1979; 2005) attempts to look at human development from a range of perspectives, accounting for the influences of various immediate and distant contexts and, simultaneously, recognizes the role that personality and individual factors play in the way a person interprets and responds to life events. To supplement the bio-ecological model, this study relied on the work of Ryan and Deci (2000; 2006), who formulated a self-determination theory (SDT) of personality and human motivation. SDT compliments the contextual model by illuminating, to a great extent, factors that are necessary for healthy psychological development.

Basic psychological needs.

Of central importance to the SDT approach is the proposition that, just as people are born with physical needs such as food and hydration, they also are born with three

basic psychological needs: relatedness, competence, and autonomy (Lynch & Levers, 2007). Relatedness refers to "a sense of belongingness with others and with one's community; it includes the presence of relationships that are characterized by mutual caring" (Lynch & Levers, 2007, p.595). Competence can be understood as "the capacity to feel and, indeed, to be effective in one's interactions with the physical and social environment…[including] having opportunities to exercise and expand one's capabilities" (Lynch & Levers, 2007, p.595). Autonomy reflects acts that are "endorsed by the self, fully identified with, and 'owned'" (Ryan & Deci, 2006, p.1561). In describing autonomy, Ryan and Deci (2000; 2006) also astutely differentiated between it and the concept of independence or individualism. According to the theorists, meeting the need for autonomy is not in opposition to a person's sense of community or relatedness, as can be implied by independence. Rather, autonomy is more about choice and personal volition, which "can accompany any act, whether dependent or independent, collectivist or individualist" (Ryan & Deci, 2000, p. 74). To the extent that the psychological needs are met, the human propensity towards natural, innate, self-motivated behavior is maintained and supported. Thus, the model recognizes that people are intrinsically motivated toward self-growth opportunities, and, at the same time, allows for the reality that environmental factors either hinder or enhance a person's attempt to meet the three basic psychological needs (Ryan & Deci, 2000; Lynch & Levers).

Motivation.

The concept of motivation is also central to self determination theory (SDT). SDT describes two types of motivation: internal motivation, which is characterized by self-directed acts, and external motivation, which refers to initiatives that are experienced as

somehow coercive or forced upon a person (Lynch & Levers, 2007). Yet, motivation is seen not just as a dichotomous reality; SDT proposes a continuum of motivation, on which internally or intrinsically motivated acts reflect differing levels of personal volition. Extrinsically motivated behavior is characterized by the least amount of autonomy on the motivation continuum. People who act from extrinsic incentives, for example, usually are thought to "just go through the motions" (Ryan & Deci, 2000, p. 72). However, external motivation can begin to mirror many of the characteristics of internal motivation when the quality of the motivation in response to environmentally determined circumstances becomes internalized and reflects personal willingness. Finally, tying together the concepts of basic psychological needs and motivation, Ryan and Deci use SDT to purport that when the basic psychological needs are met, especially the need for autonomy, the greatest support for human potential and internally motivated behavior is present.

Summary.

SDT recognizes autonomy as a basic, human psychological need and, moreover, sees autonomy as a key factor in a person's ability to transform externally motivated drives into more internally motivated pursuits. The importance of autonomy for human growth and development is echoed by the assisted living industry, whose underlying philosophy promotes the maintenance of resident autonomy. Although there is considerable debate about the industry's success at providing environmental supports for resident autonomy (Utz, 1999) because the demands of community living typically place some restraints, regulations, and schedules on ALF elders, the industry, nonetheless, holds up autonomy as an aspirational ideal.

The concept of relatedness as a basic psychological need seemed particularly relevant to this study, as well. Moving into ALFs often entails elders leaving behind their community connections with friends, neighbors, church acquaintances, and sometimes even family. Literature (Cummings, 2002) has shown that resident well-being is related to how successful ALF elders are in forming new, meaningful relationships within the facility and, thus, supports the role that relatedness plays in creating a positive transition experience.

Individual Differences and Cultural Considerations in Aging

As mentioned, the strength of the bio-ecological model is that it accounts for both individual and environmental factors that influence human development. Self-determination theory offers additional clarity about the factors of individual difference that affect the ways the person who "resides" at the heart of Bronfenbrenner's ecological model responds to environmental circumstances. To conclude this section, it seems important to look momentarily at late life development through the lens of gerontological literature.

Gerontology increasingly is taking into account the shifting demographics of the United States population; older adults are enjoying better health and longevity than previously has been seen. Theories of aging, therefore, have begun to focus more on life span development from a positive perspective, and some of the best examples of this approach are evident in theories of successful aging (Morrow-Howell, Tang, Kim, Lee, & Sherraden, 2005). Successful aging often is equated with productivity, living well, being well, and even with delaying the normal process of aging (Moody, 2005). Theories that promote successful aging are concerned with breaking down negative stereotypes and

myths about older adults and with reframing the aging process as a "normal, healthy, and even positive feature of the human life cycle" (Juengst, 2005, p. 3).

Most models of successful aging have been based largely on the experiences of healthy, well-situated individuals who remained independent in their later years but have neglected to account for the population of impaired and institutionalized elderly persons who require the help of others in their day-to-day living (Bearon, 1996). Bearon noted, however, that a "surprising development [in gerontological literature] has been the emergence of schemas for successful aging for those people who experience significant hardship in later life." New models (e.g., Lustbader, 1991) examine the possibilities for well-being and life satisfaction for individuals who are impaired, institutionalized, or dependent on others.

The discussion about successful aging—and the emergence of new models of aging for impaired and institutionalized persons—is relevant for residents of assisted living, who are likely to depend on staff members for help with activities of daily living. Within the models of successful aging, the ways in which ALF residents continue towards positive, life affirming development may find recognition. Torres (as cited in Moody, 2005) added another dimension to the discussion about positive aging when he observed that evaluation of the aging process necessarily must recognize the connection between cultural values and successful aging. Moody agreed and seemed to suggest that the relationship between successful aging and cultural values often is culturally insensitive to relational modes and social networks. Indeed, Moody (2005) stated, "What is clear is that taking for granted our individualistic, activity-oriented, and future-oriented approach to successful aging becomes an uncritical kind of cultural blindness (a kind of

cultural ethnocentrism)…" (p.59). Successful or positive aging as an approach to understanding adult development, therefore, is best applied when the nuances of various ethnic and cultural groups' values and belief systems are permitted to inform the definitions of positive aging.

Transitions, Housing, and Older Adulthood

The research discussed thus far is a sampling of a large body of scholarship that is significant to the multi-layered system of 'being' in which older American residents of ALFs find themselves, and, in its breadth, is consistent with the ecological framework adopted for this study. The second area of research that will be briefed touches on the transition experience to long-term-care facilities.

Transition and Transition Trauma

Social services and gerontological literature typically understand transitions as the move from one physical location to another, such as the relocation from an independent living environment to an assisted living environment or from a home residence to any type of care facility (Crawford, Eckert, Zimmerman, & Schumacher, 2005). In this sense, the gerontological and human services conceptualization parallels Bronfenbrenner's description of ecological transitions, which he discussed as encompassing mesosystemic moves from one microsystem to another.

Terms that are sometimes applied to the detriments of late-life relocations from and to a variety of settings, such as nursing homes, hospitals, residential care sites, assisted living, and intrainstitution transitions are relocation trauma or relocation stress. Farhall et al. (2003 p. 1023) described relocation trauma as the "adverse outcomes of relocation from one care facility to another." Doenges and Moorhouse (as cited in Morse,

2000) defined relocation stress more broadly as biological or psychosocial concerns that arise as a result of transitioning from one context to another. Some of the symptoms related to this phenomenon that appear in late-life residential relocations include the exacerbation of any current symptoms, impaired functioning, elevated death rates, depression, disturbances in behavior, grief, anxiety, and a variety of physiological and immune system stressors (Farhall et al.; Morse). The literature search revealed little by way of examinations that deal specifically with relocation trauma and assisted living; however, a number of studies dealing with relocation stress among nursing home residents were found (e.g., Aneshensel, Pearlin, Levy-Storms, & Schuler, 2000; Capezuti et al., 2004; Mirotznik & Los Kamp, 2000; Pruchno & Resch, 1988). Although the direct applicability of the findings of these studies to ALF residents is not known, the results, nonetheless, provided points of consideration for this investigation.

Extreme relocation reactions: Mortality.

Aneshensel et al. (2000) studied mortality rates, an extreme symptom of relocation stress, among people with dementia who transitioned from their homes to nursing homes. A central question of their investigation was whether or not increased mortality rates among nursing home residents are a factor of the residents' already poor health that instigates the move to nursing homes or whether the trauma of transition hastens impairment, and eventually, death. The results of the study indicated the most vulnerable time period for adjustment was within the first 6 months of transferring to the nursing home, with 26% of the 272 participants dying within that time frame. Results also suggested that the strongest predictor for these deaths was poor health. However, the authors cautioned against ruling out the role of relocation stress completely as a

contributor to mortality, because among those who were not admitted to nursing homes because of poor health, an increase in death rate also was found, even if it was not as significantly related to mortality as was poor health.

For several reasons, the results of the Aneshensel et al. (2000) study are not generalizable to the current investigation. First, Aneshensel and colleagues examined residents with dementia, while this study was interested in persons who are not cognitively impaired. Lack of cognitive impairment may signify better health among the assisted living constituents sought for the present study. Second, Aneshensel et al. were interested in the nursing home context, while this study was concerned with assisted living facilities. An argument for the importance of differentiating between the transition experiences into nursing homes and assisted living facilities already has been made. Given these differences, though, Aneshensel and her colleagues suggested the following insights about relocation that seemed useful to the task of trying to understand the experiences of ALF elders who have moved from their homes into assisted living: (a) relocation disrupts the normal, daily behavioral patterns of elders, (b) elders may not have had control over the decision to relocate, especially if a health concern accelerated the decision to move, and (c) the transition may sever important community ties that could lessen the effects of relocation.

Relocation and depression.

Depression can be a symptom of relocation stress, and, as already has been mentioned, is frequently used as a construct of interest in studies with older adults. Using a quantitative approach, Loeher et al. (2004) examined the relationship between the transition to a nursing home and levels of depression in elderly rehabilitation patients.

The researchers observed significantly higher levels of depression in hospital patients who were referred to a nursing home than in patients who were released to live alone or with others. These results support the connection between loss of autonomy and increased depressive symptomatology. The potential detriments (e.g., risk of depressive symptomotology) that appear to be related to unsuccessful transitions to nursing homes (Loeher et al.) are an indicator that an in-depth study of the relocation experience to ALFs is critical.

Qualitative Investigations of Late-Life Transitions

In one of just a few qualitative investigations into the transition experience to a long-term-care facility, Lee et al. (2002) theorized about the adjustment process through which Chinese elders progress when they move to a nursing home. The researchers concluded that newly situated residents are confronted with the realities of diminished independence, limited opportunities for decision-making, and, at the time of admission, a general sense of uncertainty (Lee, et al.). Indeed, the transition to intermediate and long-term health care settings often provoked in residents feelings of "abandonment, and loss of a home, lifestyle, autonomy, [and] privacy…" (Lee et al.). Furthermore, community living in which an individual's peers are largely aged, physically impaired, or possibly confused was a "constant source of threat to the newly admitted elders who feel their health may similarly deteriorate" (Lee et al., 2002, p. 667). The applicability of their adjustment theory for nursing homes elders in China to elderly residents in American assisted living facilities, however, is not known. Further research into the transition experience for American ALF elders, therefore, was warranted.

Assisted Living and Transition

Finally, Krout and Wethington (2003) led one of the most recent and in-depth investigations into a variety of important issues of facing elders and long term care. This interdisciplinary, longitudinal study focused on areas of decision making related to housing and subsequent adjustment and well-being; role identity and social participation of elders in LTC; health services utilization; and psychological well-being and adjustment. Outcomes of the investigation were increased knowledge about elders and housing as well as implications for policy makers. Of special note was the issue of socio-economic status and its relation to services for older adults who cannot afford to move to ALFs that primarily are private pay institutions. The authors encouraged other practitioners and researchers to continue to examine the questions they raised in their study; this investigation responded to that encouragement.

Summary

Existing research has not to this point been able to get at the important developmental tasks that emerge as a result of residential relocation to an assisted living facility or to provide a detailed account of the lived experience of older ALF residents. Unanswered are questions about the intrapersonal experiences of older adult residents such as: How do older adults manage the complexity of losses that accompany the transition to an assisted living facility? What impact does the relocation to an ALF have on older adults' perceived roles and identity? What resiliencies do residents possess that aid in the transition process? What barriers prevent elders from making a successful transition to assisted living facilities? Also untapped are larger contextual issues such as: How can staff at ALFs aid elders in the transition process? Examining the rich, in-depth,

and descriptive information that key stakeholders—residents themselves—possess about the developmental and transitional issues that emerge during relocation to ALFs was the primary goal of this study.

The Assisted Living Industry

The primary context for this investigation was assisted living facilities. Assisted living is distinguished from the nursing home model in that it typically is less costly, provides a more homelike environment, and tends to serve a less physically restricted clientele (Steinhardt, 1997). One of the hallmarks of the nationwide assisted living industry is its variability in service delivery approaches and environmental features (Utz, 1999). Assisted living sites across the United States, for example, can house from as few as two beds to as many as 200 beds. Despite their differences, most assisted living facilities share a common philosophy of how care services should be provided as well as a common history related to the emergence of these types of settings. This section will highlight the key factors associated with the growth of the assisted living industry as well as explain the general, philosophical ideals that unite ALFs. Finally, this section will describe the ALF industry in Ohio, where this study took place.

Trends in Caring for Elderly Persons: Emergence of Assisted Living

With growth trends that rival those of nursing homes in the 1960s and 1970s (Assisted Living Quality Coalition, 1998), assisted living rightly can be called the "new nursing home." In the mid-to-late 1990s, assisted living was recognized as one of the top three emerging industries in America (Steinhardt, 1997). Today, assisted living continues to enjoy growth rates unrivaled by other segments of the long-term-care industry (Brady, 2006; Utz, 1999; Wilson, 2003). In a consumer market that was crying out for a new

paradigm for senior housing and health care (Kane, 1993), the assisted living model of residential care for frail and elderly persons promoted the ideals of privacy and respect for autonomy, as well as environmental and philosophical ideals that were missing from the medically oriented approach used by nursing homes (Hernandez, 2005/6; Kane).

In 1998, Kane, Kane, and Ladd described the emerging assisted living industry as one that was like a three-legged stool, with each leg representing a unique part of the industry. First, assisted living was born from the need to create senior housing that architecturally resembled home residences more than institutions. Practically, this meant that residents would have private rooms with fully equipped bathrooms and food storage areas. Second, the industry relied less on a medical model of care and more on an approach that allowed seniors actively to provide input about their needs. Finally, the assisted living model was grounded in philosophical ideals about the importance of promoting, supporting, and maintaining resident autonomy, individuality, choice, and dignity (Hernandez, 2005/6).

From its inception, assisted living has been marked by facility-to-facility variability that continues to characterize the industry (Kane, 1993). Despite the unique "fingerprint" that marks each facility, the emergence and rapid expansion of the industry itself is characterized by some common trends. The Assisted Living Quality Coalition (1998) identified five key trends that led to the birth of assisted living: (a) consumers began to demand more choices in the housing market for frail elderly and disabled persons, (b) changes in the delivery of health care services once limited to medical doctors began to include professionals and paraprofessionals who were able to operate in a diverse range of settings, (c) civil rights advances for disabled persons began to support

their right to choose from and receive funding for a variety of living environments, (d) the market for health and long-term care providers supported by managed care started to demand a greater a diversity of settings and options, and (e) public policy started to recognize the increasing costs of providing health and long-term care services, and in trying to minimize expenditures, began to allow for Medicare/Medicaid reimbursements for assisted living.

Defining Assisted Living: Commonalities across the Industry

Assisted living is a unique industry that has emerged, in part, in response to the needs of older adults and frail elderly persons. Understood differently by different people and organizations, the Assisted Living Federation of America (ALFA; 2006, p. 4) defined assisted living as, "a special combination of housing, personalized supportive services, and health care designed to meet the needs—both scheduled and unscheduled—of those who need help with activities of daily living." Offering a more detailed definition, the Assisted Living Quality Coalition (1998), which represents a number of consumer groups and provider associations (i.e., American Association for Retired Persons, Alzheimer's Association, American Association for Homes and Services for the Aging, American Health Care Association/National Center for Assisted Living, American Seniors Housing Association, Assisted Living Federation of America), described assisted living as:

> A congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health related services; designed to minimize the need to move; designed to accommodate individual residents' changing needs and preferences; designed to

maximize residents' dignity, autonomy, privacy, independence, and safety; and designed to encourage family and community involvement (p.69).

The philosophy behind assisted living is a major point of differentiation between ALFs and other, more traditional types of long term care, such as nursing homes, that use a medical model approach to care giving. Moreover, because there are no national regulations or standards that govern assisted living, which leaves facilities to be regulated on a state-by-state basis (Utz, 1999), the industry's philosophy appears to be the strongest point of unification among individual facilities across the United States. The Assisted Living Federation of America (2006) described a ten-point philosophy of assisted living that involves: (a) offering cost-effective quality care that is personalized for individualized care; (b) fostering independence for each resident; (c) treating each resident with dignity and respect; (d) promoting the individuality of each resident; (e) allowing each resident choice of care and lifestyle; (f) protecting each residents right to privacy; (g) nurturing the spirit of each resident; (h) involving the family and friends, as appropriate, in care planning and implementation; (i) providing a safe, residential environment; and (j) making the assisted living residence a valuable community asset.

Assisted Living in Ohio

Just as there is nationwide variability in assisted living, there also is variability among ALFs in Ohio (Utz, 1999). Understanding the similarities and differences among the facilities that comprise this sector of the senior housing industry in Ohio was especially important for making informed decisions about the types of facilities that were approached for use in this research project. One excellent source of information about Ohio assisted living came from a report filed by Utz, who used mail surveys and phone

interviews with assisted living providers throughout the state to create an overview of the industry characteristics, draw conclusions about the applicability of the assisted living philosophy to day-to-day practice, identify points of variation among service providers, and recommend key regulation issues for the future. Some of her findings are presented here.

Facility Characteristics and Cost

In 1999, Utz found that assisted living facilities in Ohio were generally free-standing buildings in operation since 1993. Typical facilities housed 58 individual studio apartments approximately 400 square feet in size at a cost of, on average, $2400 per month. The monthly cost for residents, however, may vary considerably because base fees often do not include all services offered by the facility, and residents frequently pay extra for amenities such as transportation, meals brought to their rooms, and nursing services above the minimum covered in the base rate (Hawes, Philips, & Rose, 2000). Historically, all assisted living costs have been covered privately by Ohio residents, which limited the viability of this housing option for low and moderate-income elders who cannot afford the monthly costs without liquidating their assets (Hawes et al.). It has only been with the recent creation of the Ohio Assisted Living Medicaid Waiver Program in July, 2005 (enacted to serve consumers in July, 2006), that Medicaid as a payment option for assisted living has become available to Ohio consumers. The program is intended to delay the placement of older adults into nursing homes and to support their independence, autonomy, and privacy (Ohio Department of Aging, 2006).

Under the terms of the waiver program, only residential care facilities that are licensed by the Ohio Department of Health and certified by the Ohio Department of

Aging as an Assisted Living Provider may participate in the program. Requirements for consumers are that individuals must (a) already be a nursing home resident or must be relocating from their homes, (b) be recipients of the state assistance services for older adults known as PASSPORT or CHOICES, (c) meet Medicaid eligibility requirements, (d) be 21 years or older, and (e) need assistance with activities of daily living (Ohio Department of Aging, 2006). One important implication of the waiver program is that assisted living may become a more accessible housing option for low to moderate income individuals. Having just recently been set in place, however, the impact of this program on the diversity of ALF clientele was not likely to be evident in this piece of research.

Facility Services

Almost all (99%) facilities in Ohio offer to residents three meals per day, activities, housekeeping services, and linen/towel laundry service (Utz, 1999). Most facilities also offer on average 7 out of 10 of the following other services: special diet plans, personal transportation, personal care (some), personal care (all), medicine administration, medication reminder, dementia care, dementia/wanderer, pet service, and physical, occupational and/or speech therapy (Utz). Of these services, facilities are less likely to provide dementia care (73% of facilities) and physical therapy (16% of facilities). Other features and amenities that typically are found in ALFs in Ohio include, but are not limited to, the following: dining rooms, activity rooms, private gathering space for family meetings or get-togethers, a beauty shop, laundry room, and hand rails throughout the facility (Utz).

Assisted living facilities can be categorized as for profit or not-for-profit, by the size of the facility, and by the cost of services (Utz, 1999). Additionally, there is no

standardized physical model for assisted living facilities, and they can be grouped as "free-standing" buildings, part of a continuing care retirement community (CCRC), assisted living with independent living, and assisted living with nursing home facilities. The results of Utz's research suggested that facilities that are free standing or part of a CCRC house individuals with the greatest needs, while facilities with independent living serve a population of more capable older adults and are less costly.

Resident Characteristics

The Ohio Assisted Living Association (2006) reported that the average age of residents in Ohio's assisted living facilities is 83 years old and that most residents are women. Utz (1999) reported that while the needs of ALF elders vary, most require assistance with medication and housekeeping chores. In general, the men and women who live at Ohio assisted living sites do not require services beyond what is offered in compliance with licensure regulations. Residents stay, on average, a little more than two years in an ALF before moving out (55% of the time to a nursing home) or passing away.

A search for demographic factors of Ohioans who use assisted living provided little information beyond age and gender of residents. As already noted, until July, 2006 assisted living in Ohio has been paid for privately by older adults. With an average cost of $2,400 per month, this housing option has been out of reach for many elders of lower socio-economic status. In the report *The Strategic Area Plan for Programs on Aging*, the Ohio Department of Aging (2006, May) admitted that even with the creation of the Assisted Living Medicaid waiver, "the limited number of slots and the restrictions on who is eligible will provide challenges to program participants, providers, and the COAAA as we begin implementation of the program" (p. 15). The absence of a segment

of the older population who are of lower socio-economic status in this study was anticipated.

Another area unaddressed in the literature about assisted living elders is related to race and ethnicity. No demographic break-down of the number of minorities who relocate to ALFs could be found. General demographics provided by the Ohio Department of Aging (2006) and the Central Ohio Area Agency on Aging (COAAA; 2006), revealed that Franklin County, the regional area where participants for this study initially was sought, is the most diverse county in Central Ohio, with a racial make-up of 75.5% White, 17.6% Black, 3.1% Asian, and 2.3% Hispanic. Moreover, 92% of all Blacks who live in central Ohio reside in Franklin County. An absence of racial minorities in this investigation also was expected.

Chapter Summary

This chapter has reviewed a bio-ecological model (Bronfenbrenner, 1979; 2005) and self determination theory (Ryan & Deci, 2000; 2006) as two relevant approaches to conducting an inquiry into the transition to assisted living. Literature about late-life transitional adjustment to institutional settings, such as nursing homes and assisted living facilities, also was highlighted; one of the most noticeable elements of this segment of the review is that inquiries related to transitions to assisted living largely are absent from the body of scholarship dealing with older adult development and psychosocial issues. Finally, the assisted living industry has been examined as a rapidly emerging, under-examined context of long term senior care in the United States. The next chapter describes the methods used in this investigation of the lived experience of a late-life residential relocation to assisted living.

CHAPTER III

METHODS

The goal of this inquiry was to learn more about the experiences of older adults who transition from their homes to assisted living facilities. The investigative approach of the study was qualitative in nature. Denzin and Lincoln (2003) described qualitative research this way:

> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their nature settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them (p. 4-5).

Placing myself in the "natural setting" of the assisted living sites was determined to be the best approach to make sense of, and ultimately, to weave a meaningful interpretation of the transition phenomenon I was interested in coming to know more deeply.

In this chapter, I describe the research methodology and theoretical framework, research instruments, the sampling and recruitment procedures, and data collection and analytic process used in this phenomenologically oriented study. The investigation took place in five facilities in Ohio, with the permission of the directors of each of these facilities and with the cooperation of the co-researchers—the older adult residents—of the chosen sites.

Conceptual Framework

According to van Manen (1997), "the methodology is the theory behind the method, including the study of what method one should follow and why" (p. 27-28). Patton (2003) provided one guideline for deciding on appropriate methodology in human science research when he suggested that the philosophical tradition of an investigation should serve the central question under examination. The focal point of this piece of research was a wondering and a curiosity about *how* older adults experience and manage relocation from their homes to assisted living facilities. Paying attention to the voices of these elders seemed to be important to provide rich insight into the lived transitional experience that was of central importance to this investigation. Many other pieces of research have approached the topic of late-life relocation from the preferred methods of detached observation or quantitative measurement (van Manen, 1997). As a result, the very personal, intimate, and human aspects of a late-life transition to assisted living that are of interest in this study, until now, remained veiled. Therefore, instead of employing a quantitative methodology, that finally, only may have duplicated what already is known about late-stage transitions, a qualitative, phenomenological approach seemed better suited to provide a framework for yielding deeper understandings of the meaning attached to the lived experience of the ecological transition to assisted living.

Certain assumptions line the inner layers of phenomenologically-oriented research; van Manen (1997) outlined six of these assumptions, or methodological structures. They are: (a) research is interested in a particular phenomenon that sparks the curiosity of the researcher, (b) the study of the phenomenon focuses not on how it is already conceptualized (or presumed to be), but on what the phenomenon reveals about

itself, (c) reflection and analysis center on common or essential themes that emerge from the lived experience, (d) the phenomenon is described in written form (rather than through statistics), (e) the researcher must remain strongly engaged by the experience, and (f) understanding the phenomenon occurs by considering both the details of the experience and the overall meaning suggested by the experience.

In addition to the phenomenologically-oriented framework upon which this study relied, a second tradition—symbolic interactionism—was used to allow for a more systemic approach to making sense of the data that were collected. A sociological perspective, symbolic interactionism focuses on the shared meanings that people create to give meaning to their experiences (Patton, 2003). Both methodologies rely heavily on understanding personal, human experience through traditionally qualitative methods that will be described later in this chapter.

Phenomenology and Lived Experience

The concerns of phenomenological research can be summarized in the question: What is the essence or true nature of an experience of interest? (Patton, 2003; van Manen, 1997). To answer this question, phenomenological research attempts to describe, as vividly and thoughtfully as possible, the meanings or essences of lived human experiences. van Manen (1997) suggested that the "essence" of a thing should not be mystified. Rather, he stated, an essence is a good description, one that "is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way" (p. 39). As evidenced in the introduction and literature review, the phenomenon of relocation to some long-term-care settings, such as nursing homes, has been highly studied (mostly

through quantitative methods), while the transition experience of elders who move to assisted living facilities has been under examined. Moreover, the literature search did not uncover any pieces of research that have used a phenomenological approach to describing or understanding the lived experience of the transition to an ALF. Because of the noticeable void in the scholarship about late-life relocation to assisted living and because available data largely have been culled from quantitative methods, an argument can be made that this late life transitional moment needs to be looked at through new eyes—in a "hitherto unseen way" (van Manen, 1997, p. 39).

Symbolic Interactionism

Symbolic interactionism grew out of the sociological tradition and places emphasis on the way that people use symbols and shared interactions to make meanings and interpretations. This approach is important for qualitative research because it emphasizes "the importance of paying attention to how particular interactions give rise to symbolic understandings when one is engaged in exchanging symbols…." (Patton, 2003, p. 113). Moreover, as Kampfe (2002) noted, "…the symbolic interactionist theory…suggest[s] that perceptions of an event might influence the responses to and outcomes of such an event. This concept typically is supported by the literature regarding adjustment to transitions…" (p. 103). In this study, symbolic interactionism has been used to highlight the common symbols or perceptions that emerged as important to the transitional experience of moving from a home residence to an assisted living facility, as well as to make sense of common interpretations of the transition that linked participant experiences.

Methods and Instrumentation

This study was designed as a qualitative investigation and, therefore, relied on traditionally qualitative methods of data-gathering, including focus group interviews, key informant interviews, and researcher observations. However, because the co-researchers were older adults, special precautions recommended by the Institutional Review Board at Duquesne University also were used to ensure that the participants were capable of engaging in a reflective process of meaning-making that is central to describing their transition experience. Thus, the Folstein Mini-Mental Status Exam (MMSE) was included among the instruments as a way to screen for cognitive impairment.

Folstein Mini-Mental Status Exam

The Folstein Mini-Mental Status Exam (MMSE; Folstein et al., 1975; Crum et al., 1993) is a test of cognitive ability and impairment that is used both in clinical and research settings. When applied for research needs, the MMSE has been effective in screening for cognitive disorders among a variety of populations, including community dwelling and institutionalized elders (Crum et al.). In clinical trials, the MMSE has been shown to account for differences in mental status related to age and education, with increases in age and decreases in education levels corresponding to lower levels of cognitive ability. Because of the impact of education and age on mental status, all participants were asked to provide basic demographic information that includes these two areas. Interpreting the results of the MMSE was done by comparing each participant's overall score with normative data on the MMSE that has been adjusted for age and education level and supplied by Tufts New England Medical Center (2004). All residents

who were assessed at a below normal level of cognitive functioning were excluded from participation.

Focus Group Interviews

Focus groups offer several advantages on which this study capitalized. These groups: (a) are relevant because they utilize the social aspect of human interaction, (b) are malleable in terms of allowing the researcher to pick up on and explore nuances in the rich information that group members provide, (c) provide high face validity, and (d) are a low cost and efficient way of collecting in-depth data (Krueger, 1994; Levers, 2005). Krueger described focus groups as, "carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment" (p.6). In this study, I was most interested in the perceptions of residents of assisted living facilities; the defined area of examination was the ecological transition from a home residence to an ALF.

In this inquiry, I ran one focus group. When forming and engaging in the focus group, I paid special attention to creating a safe group environment for the older, resident participants. Participants were reminded of the importance of confidentiality, but they also were informed about the limits of confidentiality in a group setting. It was difficult to ensure complete confidentiality because the space provided by the activity director for the focus group was a resident common area through which nursing and other staff occasionally passed. Potentially sensitive questions, such as those questions that pertained to the residents' input about facility staff, were asked only when facility staff was not present. Finally, the language used in the focus group guiding questions was not overly academic so that participants easily were able to understand them.

Key Informant Interviews

Key informant interviews provide researchers with information that is not directly observable (Patton, 2003). As van Manen noted, one of the purposes of interviewing in the phenomenological tradition is to provide a "means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon" (1997, p. 66). Interviewees for this study were older adult residents of assisted living facilities who had relocated from a home residence. Individual interviews with these participants allowed me (a) to build on the information presented in focus group interview and (b) to come in greater contact with the perceptions, reflections, and meaning associated with the phenomenon of late-life residential relocation to an ALF.

The interviewing protocol that I used for both the focus group and the individual interviews consisted of a semi-structured interview guide that included a number of key questions related to the research question of interest. Patton (2003) outlined these advantages to using an interview guide: (a) the interviewer considers in advance how to make the best use of the time spent with the interviewee; (b) the guide provides some consistency across interviews; and (c) the guide helps to keep the interview focused on the pertinent topics. The semi-structured guides used in this study allowed me to have some flexibility to address topics that were not anticipated in advance of the interviews. The specific protocol questions designed for this study are provided in the section on Data Collection.

Researcher Observations

This inquiry, which was designed to illuminate the lived experience of elders who transition from their homes to ALFs, relied first on a focus group, and second, on key informant interviews with purposefully identified co-researchers. Lastly, I used my own unfocused and focused observations as a method of data collection (Jorgensen, 1989). Jorgensen (1989) stated that, "[o]bservation begins the moment the participant observer makes contact with a potential field setting. Aside from collecting information, the basic goal of these largely unfocused initial observations is to become increasingly familiar with the insider's world so as to refine and focus subsequent observation and data collection" (p. 82). van Manen (1997) used the term "close observation" to describe the practice in which a human science researcher "tries to enter the lifeworld of the persons whose experiences are relevant study material for his or her research project" (p. 69). He described this method further by stating that the "close observation requires that one be a participant and an observer at the same time…" (van Manen, 1997, p. 69). Thus, by employing the method of close observation, I became an instrument used to collect data about the residents and the facilities in which they resided as soon as I entered their environments. Because it is necessary to know about the research instrumentation and because some (e.g., Finlay & Gough, 2003) propose that qualitative research inherently begins with the researcher's passions, I offer some remarks about my personal interests, biases, and qualifications for conducting this investigation.

The Researcher as Instrument: My Experiences

I have worked for a significant period of time as a pastoral minister and counselor for a religious organization and a large part of my duties relate to elderly persons, some

of whom lived in assisted living facilities and nursing homes. Through my interactions with these individuals, I have noted a number of the difficulties and benefits that seem to come with institutional living. Of particular interest to me is how elders seem to adjust—or not adjust—to their living environment in nursing homes, and more particularly in assisted living facilities. These facilities are intriguing because they do offer a "home-like" atmosphere; yet, some of the individuals with whom I have interacted do not seem attracted by the environment. I have heard such comment as, "This place is just a first class prison." This type of comment peaked my interest in what elders truly experience when they relocate from their homes for an assisted living facility.

The significant amount of time I have spent with elders has helped me to learn ways to connect with and enter into trusting relationships with older adults. These interpersonal skills, along with my sensitivity to their experiences with having left their homes for an ALF, were advantageous during the interviews. As mentioned in Chapter 1, I am already sensitive to the potential risks and detriments of ALF living. Therefore, I reiterate my bias that the meaning of living in an ALF residence for elders takes on negative connotations, and because of that I particularly was aware of and sensitive to instances in which elders seemed to attach a positive meaning to the transition experience in terms of their lived space, body, time, and relationships.

Purposeful Sampling

The sampling method that was used to identify assisted living sites and participants at the sites was reflective of the philosophical framework and purpose of the study, which was to uncover thick, detailed descriptors of the ecological transition that occurs with a residential relocation to assisted living. Like the other methods used in this

study, the sampling method was disciplined by the research question (van Manen, 1997). Facilities intentionally were chosen to be representative of the variability inherent in the ALF market in order to reflect the diverse environments into which elders transition. Older adults who were preferred had transitioned into an ALF from a home residence. Consistent with the focus of the study, the participants, as well as the facilities in which the participants resided, were purposefully chosen rather than randomly selected.

Identifying the Facilities

The investigation took place in assisted living facilities located in central Ohio, a state which has in excess of 500 assisted living facilities. All sites were licensed under Ohio's residential care facility regulations. None of the facilities had consumer complaints lodged against them, nor did they have deficiencies in licensure regulations in the past 18 months that the Ohio Department of Health identified as constituting real and present danger to residents. Real and present danger is determined by the potential for harm against residents and by the degree to which a problem is widespread (Ohio Department of Aging, 2006). Thus, facilities provided at least average or higher-than-average quality of care for its residents. Additionally, the facilities represented the various types of assisted living design that comprise the Ohio market, including one free standing assisted living site, one assisted living with nursing home site, and three sites that are part of a continuing care retirement community (CCRC). All sites that were part of CCRC's had independent living components as well as components that offered personal care and nursing services similar to that provided by nursing homes.

Identifying the Co-Researchers

The target population that I identified as having insight into the developmental issues at play in relocation to assisted living was older adult residents of assisted living facilities. This group was the main 'unit of analysis' in this inquiry. Male and female residents of licensed assisted living facilities located in central Ohio were invited to participate in either a focus group, key informant interview, or both. All residents were at least 65 years of age.

Additionally, based on van Manen's (1997) discussion about lived experience research as tapping into co-researchers' reflections, and in response to his suggestions that "reflection on lived experience is always recollective; it is reflection on experience that is already passed or lived through" (p. 10), participants resided in the facility for at least 2 months and up to 5 years. The parameters I originally had identified as an optimal time frame for the residents' length of stay in the facilities was 6 months to one year. Based on literature about adjustment processes during late-life relocations and on the philosophical framework of the research methodology, I believed that residents who fit this criterion for length of stay in the facilities would provide the best opportunity for reflection on the transition experience. However, it quickly became evident during data collection that the original parameters needed to be reconsidered because of the realities of the older adults who lived at the assisted living sites. There were few residents whose length of stay at the site actually fell into the 6 month to 1 year time frame. Therefore, I decided that trying to maintain the original delimitations with regard to length of stay would prove so difficult as to become an impossibility. Adjusting the original parameters in this case, however, did not become a disadvantage. In fact, interviewing a group of

individuals who had lived at the facilities for varying amounts of time allowed me to get at a broader understanding of the transition experience and, in the case of residents who had lived in the facilities for longer than one year, to learn about how the transition process continues to unfold over time.

Participant parameters that I proposed at the beginning of this study also limited participants to those individuals who had relocated from a home residence to the facility. While the integrity of this delimitation has been maintained, I allowed for some flexibility around this parameter because of the residents' lived experiences. Once the study was underway, I realized that a number of potential participants underwent hospital stays and later spent time in a rehabilitation (nursing) facility before they finally relocated to assisted living. However, no participants had lived long term in another facility before moving to assisted living. Finally, all co-researchers displayed minimal or no mental deterioration. Moreover, none of the residents that were involved in the study lived in an Alzheimer's building or unit at the site.

Recruitment of Sites and Co-Researchers

Recruitment for this inquiry required persistence on my part as the researcher and also necessitated, in some cases, the use of my own personal contacts with assisted living facilities and with residents of such facilities. A description of the recruitment process for sites as well as for participants is provided in this section.

Gathering the Facilities

A letter describing the nature of the study and requesting permission to conduct the investigation initially was sent to directors of 17 licensed assisted living facilities in Franklin County, which is located in central Ohio. The administrator of only one of these

17 facilities (which I later designated as Site 2) contacted me after receiving the mailing, and she suggested that the director of nursing in the assisted living component of their retirement community act as a liaison in helping to identify residents who met the requirements for participation and to make arrangements for inviting residents to an information session. After speaking with the nursing director by phone, I emailed her an outline of the criteria for resident participation, which included the following: (a) residents are 65 years and above, (b) residents lived in the facility for approximately 2 months to 1 year, (c) residents transitioned to the facility from a home residence and not another type of facility (e.g., nursing home), (d) residents do not reside in an Alzheimer's unit or building, and (e) residents retain their own power of attorney. Correspondence with the nursing director extended over a 3 week period before I was able to begin the data collection process at Site 2.

Follow-up phone calls to all other facility directors were made within two weeks of sending the letter of interest, and the process of contacting the directors continued for at least two weeks. Some reasons that administrators gave for not wanting to participate in the study included: (a) the facility was too busy to assist in the research project, (b) the facility already had partnered with another university for a research project and (c) the residents were not interested. In most other cases, the directors simply did not respond to the phone messages that I left for them, and after leaving two or three messages, I decided not to continue calling. In the end, directors of two other facilities (later designated as Sites 3 and 4) agreed to allow me to approach their residents for participation in the study. To these directors or to a selected contact person (most often

the activities director or the head of nursing) I sent emails outlining the criteria (see above) required for resident participation.

Because the process of scheduling an initial information session with the residents of the first three sites was slow, I also began to make personal visits to other facilities. As a result of the personal visits, I obtained permission from an additional facility, which eventually was the first site (Site 1) where I began data collection. The last site (Site 5) that was part of this study was home to a resident with whom I was personally acquainted. She was the only resident at Site 5 to participate in the inquiry.

Meeting the Residents

The process of meeting and inviting the residents to participate in the inquiry unfolded in several different ways. In most cases, I had communicated the parameters for participation to a liaison (i.e., director, activity directory, head of nursing) at the site, and I then worked with the liaison to determine the best way to approach the residents.

Introduction to site 1 residents.

At Site 1, the facility director spoke to the residents on my behalf to determine their interest. Because most residents were open to the idea of participating, the director contacted me to schedule a date for me to begin personally meeting the residents through a method of going door-to-door to resident rooms. During the door-to-door visits, I explained the study to the residents, gathered demographic data, and asked interested persons to sign the consent form. Interviews with consenting residents were conducted at later dates.

Introduction to site 2 residents.

The head of nursing at Site 2 compiled a list of residents who fit the criteria for the inquiry and invited me to the site once she had completed the task. On the first day that I arrived at Site 2, the head of nursing introduced me to the activities director who took me door-to-door to meet the selected residents. Additionally, the activity director also invited all qualifying residents to a group session on my first visit. At the group session, I explained the purpose of the study to the residents, reviewed the consent form, and answered any questions that residents had. After obtaining consent from the residents, I conducted a focus group with five residents on the first visit to Site 2.

Introduction to sites 3 and 4 residents.

The activity director at Site 3 and the head of nursing at Site 4 each invited me to a resident council meeting, where I had an opportunity to meet residents as well as explain the purposes of the study. Three residents at Site 3 were interested in participating in the study, and after taking their names, I went back to the site at a later date to meet with them personally. During these individual meetings, I explained the consent form, obtained consent, and conducted interviews. At Site 4, the head of nursing preferred to keep copies of the consent form, which she distributed to residents who fit the criteria and who she thought were likely to want to participate. Only one resident at this site consented to participate.

Introduction to site 5 residents.

The director at Site 5 was not interested in including the entire resident population in this inquiry because of commitments she previously had made for residents to be involved in another study. However, because I was well acquainted with one resident at

this site who I suspected would be interested in participating, I asked for permission to interview this resident. The director was agreeable, and I interviewed only one resident at Site 5. I explained the study to her individually and obtained consent before beginning the interview process.

Research Design

This investigation was designed largely around a basic research agenda whose purposes were to bring to the fore new knowledge about the nature of the lived transitional experience of older adults who move from a home residence to an assisted living facility. While recognizing that the first purpose of this piece of research was to contribute new understandings about the identified phenomenon, there was also another layer of intention to this study that could be identified as applied research. Applied research helps to "illuminate a societal concern" (Patton, 2003, p. 213) and is conducted for the purposes of making suggestions for appropriate interventions relative to problems in the public domain (Patton). The individual concerns and those of national policy makers to which this investigation responded are tied to the overall demographic trends in motion in the United States. In the near future, one fifth of the American population will be over 65 years of age, which raises issues not only for baby boomers who are planning for their futures but also for the country in terms of her response to creating policy that will be attuned to the unique needs of aging American citizens. Several of the resolutions recognized by the White House Congress on Aging (WHCoA) referenced the issues of housing, long term care and mental health needs for the aged; this study, which was designed to reflect on the lived experience of older residents of assisted living facilities, responded to the WHCoA's initiatives.

Data Collection

In this investigation, I used semi-structured interview guides in the focus group and in key informant interviews to get at the essential issues of relevance in the transitional experience of moving from a home residence to assisted living. These interviews, along with my observations, served as the primary methods of data collection. Transcripts of the interviews were analyzed for common themes that reflected the nature of a late-life relocation to a long-term-care facility.

Patton (2003) stated that "often individual people, clients, or students are the units of analysis. This means that the primary focus of data collection will be on what is happening to individuals in a setting and how individuals are affected by the setting" (p. 228). Moreover, Patton stressed that decisions about who or what are the units of analysis depend on what a researcher wants to be able to state at the conclusion of a piece of research. With those statements as a guide, the units of analysis for this inquiry were older adult residents of the identified assisted living facilities. ALF elders were selected because one of the proposed outcomes of this study was a rich and descriptive statement of elders' lived experience of the transition to long term care.

An interview protocol was designed for use with focus group participants and with individual interviewees. In creating the protocol questions, I attempted to bracket my assumptions about the transitional experience of residential relocation in order to allow the experience of relocation to emerge from the voices of the co-researchers. I learned throughout the process of data collection that bracketing assumptions is a continual process. In more than one interview, I was confronted with the life story of a participant that did not fit with the assumptions I made about late life transition, and

consequently, I had to be open to the interviewees's experiences and try to understand those experiences.

Protocol questions reflected, as much as possible, the theoretical framework of this investigation (ecological) and the methodological framework (lived-experience) of the study. Bronfenbrenner (1979) proposed that development is a contextual matter that takes place whenever a person experiences a shift from one system to another. Development is influenced by a person's interaction with elements in immediate (e.g., family, peer and work relationships) and distant systems (e.g., societal ideologies, legal entities, social policy). Thus, development does not occur only in tandem with a person's ability to wrestle with and resolve intrapersonal conflicts (as may be suggested by some psychological approaches to development) but also in response to environmental factors and relationships.

At the same time, the research methodology of this inquiry was predominately shaped by literature about lived experience research. Lived experience research tends to focus on participants' very personal reflections and meaning-making processes. To deal with what on the surface seemed to be an apparent contradiction between the theoretical and methodological frameworks—the one being rather contextually oriented and the other rather intrapersonally slanted—I relied on van Manen's (1997) proposition that lifeworld existentials can be used as guides for reflection and interview questioning. The four fundamental lifeworld existentials include spatiality, temporality, corporeality, and relationality. Lived space, lived time, lived body and lived relationships are considered essential elements to any human experience and as such, "are productive categories for the process of phenomenological question posing, reflecting, and writing" (p. 102). It is

easy to see how van Manen's concepts of lived space, time, body, and especially relationship compliment the ecological backdrop to this study and suggest that meaning-making reflection inherently and fundamentally accounts for issues of context such as space, place, relationships, and physicality.

Data collection relied on a focus group interview lasting approximately 60 minutes and key informant interviews, most of which spanned approximately 45-90 minutes. Additionally, participant observations and notes were used as data resources. Each participant was asked to provide consent for participation and was informed of potential benefits and hazards of participation. To protect the anonymity of the co-researchers, each person was assigned a code that was used in the process of analysis. As the researcher, I was the only person aware of the identity of the participants and their corresponding codes.

Focus Group Protocol Questions

The main research question posed in this inquiry is: How do older adults experience the late-stage life-span ecological transition when they permanently relocate from a home residence to an assisted living facility? Protocol questions were used to try to understand the overarching research question. Questions asked during the focus group were: (a) How have you adjusted to living in an assisted living facility after leaving your home?; (b) What are the factors that made the transition easier for you?; (c) What things "got in your way" or made the move to an assisted living facility difficult?; (d) Tell me about the changes in the relationships in your life since your move, for example, with your family members, peers and friends, staff in the facility, and other residents.; (e) How has the move had an impact on your physical health?; (f) Is there anything else you would

like to tell me about the transition you made into this assisted living facility?; (g) What recommendations would you make to the directors of your facility as aids in making the transition process easier and smoother?

Key Informant Protocol Questions

The protocol questions that were used during the key informant interviews are: (a) What has the move to an assisted living facility meant to you personally?; (b) Have you discovered any benefits to moving that you did not anticipate?; (c) Is there anything about the move to assisted living that surprised you?; (d) How has the move had an impact on your social relationships and who you spend time with?; (e) How has the move to assisted living had an impact on your perceived roles in the social environment or your sense of identity? (f) How has the transition had an effect on your financial situation?; (g) How has the move to assisted living had an impact on your physical well-being? (h) When you moved to assisted living, did you have to give anything up that was of value to you (e.g., possessions, activities, social relationships, activities)? Tell me about those things; (i) What has been the most difficult part of moving to assisted living?; (j) What factors helped you the most to adjust to your new living arrangements?; and (k) What suggestions would you make to other men and women who are contemplating relocating from their homes to an assisted living facility?

Data Analysis

"Expressing the fundamental or overall meaning of a text is a judgment call" (van Manen, 1997, p. 94). van Manen's statement about data analysis alludes to the flexibility inherent in qualitative data analysis; however, qualitative analysis also is a rigorous process that must be true to the theoretical and methodological approaches of a study. In

this case, data analysis largely reflected the lived experience methodology that is the backbone of the investigation.

Analysis began as soon as data were gathered and proceeded until the collection process was completed. Thus, the analysis of this inquiry could be considered "iterative and recursive" (Levers, 2002), which is typical of qualitative research methods. Transcripts of focus group interviews, and later, individual interviews, were read, reflected upon, and analyzed for common themes, "units of meaning" (Kruger, 1979) and "lived experiences" (van Manen, 1997). Themes are points of focus, simplifications, and ways of encapsulating the essence of the phenomenon under study (van Manen, 1997). van Manen (1997) provided four "guides for reflection" (p. 101) that researchers can use to structure analysis: (a) lived space, (b) lived body, (c) lived time, and (d) lived human relation. Likewise, Patton (2003) suggested that researchers can use "sensitizing concepts" (p. 456) to orient the analysis. The concepts of lived space, body, time, and human relation were used to create structure for analysis, with sensitivity to the reality that "concepts are never a substitute for direct experience with the descriptive data…[and that]…what people actually say and the descriptions of the events observed remain the essence of qualitative inquiry" (Patton, 2003, p. 457).

Early analyses formed and informed the data collection process by reshaping the kinds of questions that were asked and probes that were made after insights were gained through analysis. A cross analysis of the emerging themes and patterns in the focus group interviews and the key informant interviews along with observations and notes were made to generate "thick descriptions" of the data, and thereby, of the experience of the transition to an assisted living facility (Denzin, 1989), as well as to help increase the

validity of the results (Patton, 2003). To enhance the trustworthiness of the findings, I consulted continuously with the literature about the psychosocial aspects of late-life transitions to long term care, as well as with experts throughout the process of analysis. The analysis, therefore, took on an inductive design characterized by the building and forming of categories and themes out of the details of the data.

Analysis of data continued until no new themes emerged from the data and until the themes that did emerge constituted an integrated description of the residents' experiences. When no new ideas were able to be identified from the taped interviews, the analysis was considered complete. Glasser and Strauss (as cited in Rubin & Rubin, 1995) call this "theoretical saturation."

Limitations

One of the more obvious limitations of many qualitative investigations is the inherent lack of generalizability of the findings. The results of this study were drawn from a comparatively small sample of participants who were specially chosen. This aspect of the research design and data collection method inhibited the generalizability of findings to large groups of elders who transition from their homes to assisted living facilities. I also recognize that the potential for bias is present in the participant sample and research findings simply because participants offered their own, personal understandings, reflections, perceptions, and meaning of the transitional experience.

Chapter Summary

The methodological approach that primarily undergirds the research design of this study is phenomenological. Because the goal of this investigation was to better understand the lived experiences of older adults who transition from their homes to

assisted living facilities, the phenomenological approach seemed most appropriate. The research design relied on methodological triangulation, including the use of focus group interviews, in-depth individual interviews, and literature about human development, motivation, and older adults' transition experiences to other types of care facilities, such as nursing homes.

There were a total of 14 participants in this inquiry. Five residents participated in the focus group interview, and 10 residents, one of which was a member of the focus group, participated in in-depth individual interviews. Data that emerged from the interviews with residents of five assisted living facilities, when considered together with the relevant literature, produced a rich set of themes that characterize the transition phenomenon. A cross-case analysis of themes was part of the analysis process. Details of the interviews, as well as the cross-case analysis, appear in Chapter 4.

CHAPTER IV

RESULTS

Peshkin (2000) described the interpretation and analysis of qualitative data as a "retrospective account of the unfolding course of ideas" (p. 5). Because qualitatively oriented inquiries emerge from the researcher's own passions and curiosity about a particular experience, the accounting of results becomes an expression of the researcher's journey into understanding the phenomenon (Finlay & Gough, 2003). This chapter is concerned with presenting the data that were collected through focus group and individual interviews and with providing a description of my own journey into learning more deeply about older adults' lived experiences of transitioning from their home residences to assisted living facilities.

At the conclusion of his article about the nature of data analysis in qualitative research, Peshkin (2000) briefly outlined some of the conceptualizations about interpretation that guided his research. These statements were helpful as I began the data analysis for this piece of research, and, in a sense, represent my assumptions about the interpretive process. The conceptualizations are: (a) interpretation is grounded in the questions, wonderings, and ideas that have been present from the outset of the investigation (some of these ideas are reflected in the protocol questions that guided the interview processes); (b) analysis of data emerges from the vantage point from which the researcher chooses to look at the phenomenon; (c) interpretation is related to the researcher's decisions about what data to collect in light of hypotheses about what is taking place in the experience; (d) analysis is related to what the researcher chooses to write that substantiates the hypotheses about the phenomenon of interest; and, finally, (e)

interpretation is a way to account for what has been learned from the researcher's interactions with co-researchers', their stories, and other pieces of data gathered from the environment. The results of this study are offered with these five assumptions about the interpretive process in mind.

Peshkin (2000) also acknowledged, as do I, that it is impossible to conduct any study and interpret that study's data without excluding some perspectives. Decisions about what data mean or what experiences symbolize must be made, and these decisions highlight particular perspectives, while casting shadows on other points of view. As was mentioned in the literature review, the theoretical framework that was constructed for this investigation into the ecological transition represented by a late-life move from a home residence to assisted living largely is developmental and bio-ecological (Bronfenbrenner, 1979; 2005). Another perspective that significantly has informed the interpretive process is related to human motivation and self-determination (Ryan & Deci, 2000; 2006; Lynch & Levers, in press). During the analytic process, data also were triangulated with social constructionist and positive aging models that facilitated rich interpretative potential regarding the meaning of the transition and of the aging process in Western society (Gergen, 2000). Lastly, the methodological approach of this study, which was grounded in a lived-experience perspective (van Manen, 1997), was influential in organizing and structuring the data.

Residents' Demographics

The data that were collected for this study came from a total of 14 residents residing in 5 facilities in the central Ohio area. One focus group interview was conducted with 5 residents at Site 2, and 10 in-depth individual interviews were conducted with

residents living at one of the five participating sites (one in-depth interview was conducted with a focus group participant). The average age of the participants was 85.17 years. The youngest person interviewed was 75 years old and the oldest person was 98 years old. Other relevant information about the participants is summarized below. Demographic data, including residents' gender, marital status, education level, racial background, and length of stay in the facilities is provided in Table 1 and Table 2.

Table 1

Residents' Demographic Data

Gender	Number of Residents
Male	4
Female	10
Education Level	
Elementary School	0
High School	11
College Degree	1
Graduate Degree	2
Marital Status	
Married	1
Divorced	1
Single	1
Widow(er)	11
Racial Background	
White	14
African American	0
Hispanic/Latino	0
Asian/Pacific Islander	0
Other	0

Table 2: *Length of Stay in Facility*

Time	Number of Residents
0-6 mon	5
6-12 mon.	2
1-1.5 yr	2
1.5 – 2 yrs.	2
2 – 3 yrs.	1
3 – 5 yrs.	1

As stated previously, it was important to protect, as much as possible, the identity both of the individuals and the facilities involved in this study; both residents and directors of facilities were provided with assurances that their privacy would be maintained. Therefore, pseudonyms have been used for individual residents as well as for the facilities that permitted me to conduct this research with their constituents. Additionally, any significant or unique identifying elements, particularly of the facilities, have been altered or omitted to protect the anonymity of the sites. While specific details or descriptions might be of interest, protecting the identities of co-researchers and assisted living sites outweighs potential benefits that could be gained through such descriptions.

Context: The Facilities

All of the facilities in this study are located in Ohio, and they represent a range of facility types, including free-standing assisted living facilities, assisted living facility with nursing home components, and assisted living as part of continuing care retirement communities. Table 1 indicates the number and type of facilities that I visited during the data collection process. In the following sections, I provide a brief description of each of the facilities visited.

Table 3

Summary of Facility Types

Facilities Visited	*Type of Facility*	*Size of Assisted Living (by # of AL Rooms)*
Site 1	Free Standing	44
Site 2	Assisted Living with a Nursing Home	36
Site 3	CCRC*	38
Site 4	CCRC	60
Site 5	CCRC	60

* CCRC = Continuing Care Retirement Community

Site 1: Free- Standing Assisted Living

Site 1 is a non-religiously affiliated, single building, free standing assisted living facility located near several residential communities. Behind the well-landscaped facility is a large grassy area and a wooded surrounding that provide a sense of privacy and contribute to a rural, country atmosphere.

As soon as I entered through the outer doors and stepped into the foyer of the facility, I was struck by the obvious attempt to make even the entry way an inviting space. There were several floral arrangements on the walls and above the door, as well as a small bench for sitting. In order to enter the facility, however, I had to ring the doorbell and wait for a staff person or resident to let me in. The facility was locked to the general public.

The front door opened to a large common living space furnished with several sofas, chairs, and a fireplace. Behind this living space was a sunroom that also was attractively furnished. On either side of the front door were administrative offices; there were only two such offices in the facility, and the doors of the offices were open. As I waited to meet with the director, residents and their family members stopped in to talk to the administrative staff.

The building was laid out as a large square, around the perimeter of which resident rooms were situated. In the center of the building were two other living spaces with comfortable furniture, fireplaces, and the dining area. Seasonal decorations were found throughout the facility. I noticed that there was no nursing station anywhere in this facility, and that fact was confirmed in several individual interviews I had with the residents. I also learned that the small staff at this site was required to "multi-task." When they were not cooking, staff members would help residents, clean resident rooms, or aid with activities. The director also wore many hats, including leading and planning activities, taking care of administrative duties, and managing and hiring.

Site 2: Assisted Living with Nursing Home

Site 2 is a non-religiously affiliated facility located in a middle-to-upper middle class suburban area and on the edge of a highly populated business district. It is one of five nursing and assisted living sites that are privately owned and operated by its parent company. The site is comprised of both a skilled nursing facility and an assisted living component; the two facilities are interiorly connected. The nursing component of Site 2 is almost twice as large as the assisted living component, which has 36 private suites. According to Utz (1999) 60% of assisted living facilities with nursing home components in Ohio are privately owned and for profit; Site 2 is part of this majority.

Although Site 2 was attractively landscaped and well maintained, it did not have the quaint, home-like atmosphere that permeated Site 1. The parking lot was large and overbearing, as was the building itself. When I entered this facility, the interior door of which was locked, I noticed a suit of offices off to the right and a small welcome desk that was attended by a staff member. When I introduced myself to the attendant and

requested to talk to the nursing director with whom I had been in touch to arrange the logistics of meeting the residents, the attendant used the loud speaker system to call the nursing director to the lobby. At that moment, I was struck by how typical that type of building-wide communication system is to a nursing facility.

At the center of the small lobby were a few decorative furnishings and a small table with a coffee urn and cups on it. Two long halls extended off of the lobby which led to the two main living quarters of the assisted living residences. I later learned from the activity director, who helped me to gather a group of residents for a focus group and who introduced me to all of the residents who were invited to participate in the study, that the left hall housed the residents who needed more regular assistance. The left hall was situated closest to the nursing station.

Some suites at Site 2 have separate living and sleeping quarters, while most are arranged as a combined sleeping and living area that accommodates a single bed, minimal furniture, and a small kitchenette. Private bathrooms are standard in the suites as are temperature controls. Resident rooms that I visited were all decorated with some personal furnishings.

My general impressions of Site 2 were that, while it was nicely decorated and clean looking, the environment had numerous characteristics that indicated an institutional feel, including the intercom speaker system that was used to contact staff personnel, the nursing station, the nurses themselves who were present throughout the building, and furniture that was typical of that found in nursing homes rather than soft, plush chairs and couches that usually are found in private homes. The fact that this site was a combined nursing home and assisted living facility was somehow evident in the

environment. Although I wondered what impact the dual types of services offered at this site (nursing and assisted living) might have on the residents' sense of autonomy, dignity, and independence that are part of the philosophies of assisted living but that typically are less emphasized in traditional nursing homes, I did not find any major thematic differences among the residents at Site 2 and those at the other sites.

Site 3: Assisted Living in a Continuing Care Retirement Community

The third site that I visited was an assisted living facility that was part of a larger continuing care retirement community (CCRC). This facility housed approximately 40 individuals in its ALF, which was interiorly connected to an independent living building. A newly constructed nursing home also is part of the complex of this CCRC; however, the nursing home is not connected to the assisted and independent living building by any covered or interior walkway.

Site 3 is a religiously affiliated facility and is set away from a well-traveled road and was surrounded by grass and trees, as well as a paved walking path. When I entered the facility, I noticed that the front doors were not locked, unlike at Site 1 and Site 2. The lobby had a warm and inviting feel to it that was enhanced by a fireplace and numerous chairs arranged conversationally. Two residents were in the lobby when I arrived and were talking to the assistant director, who had a dog with her that apparently lived at the facility. Directly behind the lobby was a large gathering space, that I later learned also was used as a chapel. Two wings extended off of the lobby—one to the left and another to the right, leading respectively to assisted living and independent living.

At this site, I was invited to lunch by one of the residents and so was able to participate in and observe the dining experience. I noticed that the tables were placed

spaciously apart from one another to allow for wheelchairs and walkers. The environment had a formal, yet welcoming atmosphere to it. Each table was decorated with seasonal arrangements; the room itself was surrounded by windows on three sides that provided an open, airy feel to the dining space and allowed residents to overlook the outdoors. Residents were served lunch at their tables and each had designated spots at the tables. Staff members were accommodating and attentive.

Besides noticing the helpful behaviors of the dining staff, I also experienced the activities director as kind and hospitable. During one visit to the facility she greeted me with a hug and a smile, even though I had only met her once before. Especially because of the interactions I had with the staff, I formed the impression that Site 3 was an open and welcoming environment.

Site 4: Assisted Living in a Continuing Care Retirement Community

Site 4 is a religiously-affiliated, non-profit continuing care retirement community. When I arrived on site, I was immediately overwhelmed by the size of the complex and later learned from the nursing director of the assisted living facility that the CCRC was located on 11 acres of property. Visible from the parking lot was a senior apartment building that constituted the independent living quarters. This building was attached to another facility, which housed the assisted living facility as well as the dementia and Alzheimer's care facility. An overhead walkway connected the main buildings to a health clinic. All of the buildings were attractive; especially the health clinic, which resembled a private home.

More striking than the size of this complex was the lively activity that I observed as I entered the main lobby of the independent living and assisted living buildings.

Several older adults were lounging in the lobby or milling about. As I approached the receptionist, I noticed that two older adults were busily working with her. Although the décor of the facility was somewhat dark and did not exude the quaint, cozy feel like Site 1, there was a vibrancy that emanated in the lobby that came from the older adults themselves. As I walked down a main hallway to the assisted living wing, I noticed a wall on which was hung a row of professional photographs of the current and past presidents of the resident council. The involvement of the older adults in the office area in the lobby, the noticeable coming and going of older residents through the lobby, and the clear attempt to highlight the leadership of the resident council all informed my impression that this site promoted the active involvement of its residents.

Site 5: Assisted Living in a Continuing Care Retirement Community

Site 5 was one of three continuing care retirement communities (CCRC) that I visited. On the grounds of this complex were four types of living options, the least restrictive or most independent of which were condominiums with attached garages. Also on site were a multi-story independent, apartment-style living facility, an assisted living facility and a residential care facility designated for older men and women with dementia or Alzheimer's disease. This CCRC was a religiously affiliated, non-profit organization.

The assisted living component of Site 5 was interiorly connected to the independent living facility. I toured both the independent and the assisted living facilities and each one was inviting, warm, and home-like in décor. The assisted living building boasted a sitting area with a fireplace directly inside the front doors and numerous residents were sitting together when I arrived. A dining room was located at the back of the front lobby, and a grand staircase led upstairs to the second floor, which helped to

create a formal atmosphere. There were also elevators in the main lobby for residents who could not manage the stairs. I did notice that the independent living facility, which is less than a year old, was more elegantly decorated than the assisted living component and had a front desk that was attended by a staff member. The assisted living building also had a receptionist's desk, but it was not occupied. I later learned from an interviewee that once the new, independent living quarters were completed, the receptionist's desk in the assisted living was no longer attended. If residents in the assisted living facility needed attention, they could call over to the independent living facility or walk there via a long hallway. My general sense of Site 5 was that it was very well maintained and tastefully decorated. There was a quietness to the facility as well that I detected because there were few residents in the common area and little interaction among the residents who were in the lobby.

Organizing the Findings

The main themes of the focus group and individual interviews are presented below. During the recursive process of data collection and analysis, I reflected on the emergent themes in light of the theoretical models that frame this inquiry, specifically, a bioecoglogical model (Bronfenbrenner, 2005) and self determination theory (Ryan & Deci, 2000, 2006). I consulted with the members of my dissertation committee about the details of the interviews experience, and through the process of consultation, also began to consider the findings against the backdrop of social constructionist and positive aging theories (Gergen, 2000). The findings of the inquiry are organized according to four major categories that rest on the theoretical bases mentioned above. The categories are: (a) precipitating factors to the transition, (b) biopsychosocial risks of transition, (c)

evidence of power, aging, and subjugation of the older adult, and (d) supportive factors in the transition and examples of aging in positive or life-affirming ways.

Focus Group Interview

The focus group interview was the first attempt at data collection at Site 2 but took place after I had already conducted three individual interviews at another site. The participants in the group included five residents—two men and three women—and myself. All of the participants had lived at the site from between 2 and 8 months and had relocated from single family homes, condominiums, apartments, or an independent living facility. The average age of the residents was 88.4 years old; the oldest participant was 90 years old, while the youngest was 87 years old. According to the literature, these residents would be considered among the "old-old" segment of the population.

Comments on the Process

Initially, I was not planning to lead the group on the day that I met the residents, however, I noticed with this group, as I did with the individuals I interviewed, that as soon as I explained the purpose of the study, they were eager to share their stories. It seemed prudent to begin with data collection while the interviewees were gathered and ready to participate in a group rather than just describe the study and ask them to sign the consent forms. For one hour I talked with the residents about how they had made the transition to Site 2, the meaning of the relocation, advantages and disadvantages to assisted living, the role of family in the transition process, and recommendations for other older adults and for facility staff.

A number of themes emerged in the focus group that also were confirmed in individual interviews. However, I identified several limitations to the group that I think

are worth acknowledging because they may have hindered the depth of sharing that occurred. First, the group of five individuals was small, and therefore, was limited in its diversity of viewpoints. One of the members was extremely hard of hearing, which was a challenge. I tried to be sensitive to this member's needs and often repeated comments or questions to her so that she could be involved in the discussion. Additionally, the interview took place in a semi-private lounge that was located at the intersection of three hallways. Staff members walked past numerous times during the group session, and at one point, a nurse came to take one group member for a medical procedure. This member returned about 10 minutes later. The intercom system also was used during the interview, and I think this might have interfered with some members' ability to hear the conversation. Finally, I wondered about the residents' willingness to share as openly and honestly as they would have in an individual interview. For example, one woman talked about the significant change that came with "group living." Immediately after her comment, though, she said "Please, don't misunderstand me, the people here are all nice." Despite these hindrances, the group members responded to all of the questions and provided important insights into the transition to assisted living. The major findings of the focus group are described below.

Precipitating Factors

Two chief findings emerged to explain how the older adults in the focus group relocated to assisted living. The most universal explanation was health challenges; another prominent reason was a desire among the elders not to be a burden to their families.

Theme 1: The challenge of ill health.

In an individual interview I had with one interviewee who resided at Site 1, I learned that, "We [residents] all have our own struggles; it's just that the details of our stories are different." The truth of this statement became clear as I began to consider the factors that precipitated members' decisions to relocate to Site 2. Health challenges—worse in some cases than in others—seemed to underlie the experiences of all group members. Jack, one of two members who was in a wheelchair, said: "I'm here because I fell, and I had to go in the hospital. I had a blood clot on my brain, and they had to drill with steel drills." He spent a period of time in a rehabilitation center before ultimately moving to Site 2. Jane also specifically identified a health problem that led her to relocate. "I'm here because of my blood pressure," she explained. Patrick, the other resident who was in a wheelchair, struggled with walking and agreed that things at home were getting difficult: "I realized it. It was coming up fast." The healthiest of the group was 90 year-old Rita, who said that she had never battled any serious health crisis; however, she did have a fear of falling and had begun to use a walker. The interviewees identified these health challenges as the primary reasons for relocation to Site 2.

Theme 2: Desire not to be a burden.

If a health crisis had not led immediately to the relocation to assisted living, the desire not to saddle their children with their care was a strong motivating force for transitioning to assisted living with which almost all of the group members could identify. This powerful theme seemed to reflect group member's desire to retain their own independence as well as protect the freedom of their family.

Patrick introduced the topic at the start of the group by stating, "I was going to have to stay with one of the kids, and I didn't want to do that. I've seen that happen, and I didn't like what I saw." The theme re-emerged later when I asked the group if anything had surprised them about the transition to assisted living, and this led to a full discourse that Rita introduced. "I think we can be grateful that they have places like this for older people. As Patrick said, you don't want to be a burden to your family now. They have their lives to live, and they need to be free to live them." Jane thoughtfully agreed, and nodding her head said, "How true that is. That's one thing that I never want to live with any of my children because I just don't want to be a burden to them. I don't think it makes any difference how kind and how loving the children are. It disrupts their way of living to a certain degree." Rita recalled next that her own mother lived with her husband and her for 21 years and said, "I know what that was like." Noreen stated, "I have never, ever had the feeling of being a burden to my children. Ever." Jane summarized the strong group sentiment that being a burden was neither desirable nor acceptable:

> I think there's some people that actually believe that their children owes them if they get to the point where they can't take care of themselves, and personally, I don't feel that way—absolutely not. To a certain extent it would disrupt their life and if I had to live with it...with a son or daughter, ah, I'm the type of person that would cause the least amount of trouble as possible because anything that I can do myself, I don't want anyone else doing it for me. But at the same time, it disrupts their life. I don't care who it is, and I know there are many kids who do it willingly, and they don't think anything about it. But that's the way I feel.

Finally, Rita disclosed that her son and daughter-in-law who live in the Midwest invited her to live with them when she was no longer able to care for herself, and she declined their invitation. "My son in [City] said, 'Mother when you can't take care of yourself, we want you to come live with us. You took care of your mother and now we'd like to do it.' Even though I'd be welcome, they have a busy life, and I prefer this. I want them to continue [with their life]. This I can do for myself."

Biopsychosocial Risks of Transition

Bronfenbrenner (1979; 2005) described human development as the life-span phenomenon of continuity and change that occurs with a person's reciprocal interactions with a set of environmental contexts; furthermore, he noted that any ecological transition (or move from one context to another) is an opportunity for development. Although late-life transitions may present developmental opportunities for older adults, these transitions also have been described as among the most stressful life events for elders (Mead et al., 2005; Myers, 1988). Indeed, in the focus group (and individual interviews), a number of risk factors, or elements in the biological, psychological, or social environment that interrupt the normal developmental pathway (Lynch & Levers, in press), emerged. One prominent risk factor was described by the focus group members.

Theme 3: Independent no more.

After I listened to the accounts of how their transitions were initiated, I asked the group about the greatest difficulties they encountered as a result of their relocation to Site 2. A theme that resonated with the group was related to the loss of independence. In a variation of a statement that Noreen made at least three times throughout the course of the group interview, she said that the most significant challenge was, "[l]osing my

independence. I was used to independent living, and this is altogether different." Patrick and Rita nodded their heads in agreement to this statement, and then Rita responded, "I lived 25 years alone, and I miss having a car when you can go and come when you want to or need to." Jane agreed, too, and said, "It was quite an adjustment for me because I lived independently all my life…and worked all my life until I was almost 79. This kind of living is not really for me, and I hope I'll be able to take care of my own blood pressure. I have other plans to make, though I'm sure yet what they are. Being independent and taking care of my own business is the most important thing in my life." Later, Noreen again expressed her sense of lost independence by saying:

> I've made new friends here, and I try to be a good friend myself, but it's still much, much different than the way I lived before. The biggest difference, I think, would be I used to set my own schedule. I would come and go as I please, but I don't do that here. I think I've lost my sense of being independent. Not altogether, I still have independent thinking, but group living is much different to me than the way I was living before.

Before the group concluded, Noreen re-emphasized her experience a third time: "I miss the feeling of being independent. Can't help it."

Power, Aging, and Subjugation

Gergen and Gergen (2000, ¶ 2) described the individualist ideal, or the ideal of being a "free agent, capable of making his/her own decisions, choosing his/her own way of life," as a prominent value in American culture and one that is jeopardized in older adulthood. What, then, is it like to experience the loss of independence? Several interesting themes unfolded throughout the group process suggestive of a conflicted

response to this loss. By one account, elders recognized, verbalized, and even resisted or mourned the loss of independence that was symbolized in the transition to assisted living. "It isn't something you would choose to do," Rita said, "but in the long run you are better off. Do it and forget it." When she described how she felt when she first moved in, Rita admitted that "it was a real struggle." When I asked her to talk more about that period, she offered a powerful metaphor and said it was "like I was in jail." Another resident said, "I miss the life I had." Jane, as mentioned above, said, "…this kind of living isn't really for me."

In other, subtle ways, the residents appeared to be complicit with a socially held belief system in which decline and degeneration in old age are seen as natural, expected, and not to be fought nor publicly protested (Gergen & Gergen, 2000; 2003). I identified three ways that group members supported and were subject to a belief in a naturalized life course that essentializes decline in old age. I describe these experiences as: (a) "Sweeten the Bitter Pill", (b) "Surrender to the Circumstances", and (c) "Walk the Line".

Theme 4: Sweeten the bitter pill.

The first sign that the interviewees had accepted a socially constructed, naturalistic definition of aging surfaced in what I experienced as group members efforts to mitigate the negative effects of transition by negating any unfavorable features of assisted living or of personal struggles with the transition to assisted living. Noreen was an excellent example of an interviewee who tried to "sweeten the bitter pill" of transition to assisted living. Only moments after she said for the first time that losing her independence was the most difficult adjustment for her, she also said, "Now, please, don't misunderstand me." The second time Noreen joined in the conversation she said,

"It's altogether different living with other people than living by myself" and only moments later softened her statement, "But, please, don't misunderstand me, I enjoy the fact that I've made a lot of new friends here…" On a third occasion she contributed, "The fact is, I just got used to living by myself. Going and coming as I pleased…and now it's an altogether different story." Seconds later Noreen made this statement, "Chrissy, don't misunderstand me. I treasure the new friends that I've made here, but it's an altogether different environment…."

Theme 5: Surrender to the circumstances.

In a similar vein, Rita seemed to have adopted an attitude of surrender with regard to her situation in assisted living. For example, when I asked her how she managed to make it through the struggles she associated with the transition to Site 2 and especially the sense of being jailed, she responded that she was able to become content "because it's an easy life, and it's sheltered, and I'm ok. I don't expect to be here long… I don't expect to be living that much longer, so I might as well enjoy it." She also reasoned with herself, "I don't expect to live now like I did in the early years." And, while she admitted, "I miss the life I had," she resolved, "I'm going to make the most of this one." Rita made a strong effort at convincing herself that although she loved the independence of going out in her car, now that she was at Site 2 this time in her life was not about going out or being busy, but rather, about settling down and slowing down. "Do and forget it," she remarked sensibly. Finally, Rita stated, "Make the best use of your time when you're young. Do what you want to do," which highlighted a division in thinking between being old and being young.

Theme 6: Walk the line.

Finally, Jane introduced another nuance that suggested the naturalized life course was highly valued in assisted living when she spoke about the importance of acclimating to the transition. "I think they [residents] just have to accept the fact when they come in and adjust to it rather than making everybody miserable around them. I know there are a couple here that have decided they are not going to adjust, and they make it miserable not only for the people around them but for themselves also. I don't have much sympathy for them. You have to do what you have to do. It's just the way it is." Noreen voiced her agreement, "You have to go along to get along," and head nods from the rest of the group followed her statement.

Positive Aging and Supportive Factors

From a social constructionist perspective, the construct known as aging is created through a relational, cultural interchange in which some values are reinforced as the most prized; among them in Western society are the values on individuality and independence. Gergen and Gergen (2000; 2003) suggested that possibilities for "cultural transformation" in the area of aging are becoming increasingly evident as elders transcend the constraints of traditional cultural stereotypes and myths about aging. Gergen and Gergen's proposition of a "new aging" provided a way to triangulate some of the emerging themes in the focus group.

Theme 7: Sense of autonomy.

Being to some degree complicit with the transition to assisted living and the loss of independence that it seemed to usher in was not the only response that the interviewees had. When asked about the aspect of what Noreen called "a regulated way of living" that

seemed to be part of the transition, Patrick stated, “I still feel free. I just tell them [assisted living staff] I’m going someplace and they accept it.” Likewise, Jack said, “I can go wherever I want, do whatever I want.” Jane agreed and said, “I always make my own decisions.” Later, to substantiate and put example to his agency, Patrick said of his financial freedom, “My daughter took over all my finances. If I need anything, all I’ve got to do is tell her. My other daughter is married and her husband is not worth a whole bunch and her computer went out and she depends on that for part of her work. So I bought her one. Just called [Daughter] and told her to buy her one.”

Theme 8: Maintain current relationships.

Witnessing to another positive aspect that highlighted his relational life, Jack stated of his community ties, “I still have my friends. I pick up the phone and call them. They call me and, you know, we keep in touch.” Patrick said of his friends, “They keep in touch. I can call them. They call me.”

Theme 9: Staff attentiveness as a support.

Moreover, a few members of the group talked about the kindness of the nurses and aids that served as a supportive factor to them. “I never heard a nurse or an aide speak unkindly to another person. I’ve heard those horror stories about rest homes and this isn’t like that at all,” Jane said.

Theme 10: Involvement in the decision to transition.

Jack also mentioned that he was involved in the decision to move to assisted living. One of his recommendations for adults in his situation is to “get fully acquainted” with the facility and to engage the decision making process by “studying what they are doing and where they are going.” He mentioned that his family soon may be moving to

another state and that he is going with them and will move to another facility. “They brought me the literature and so forth about another facility and I’ve read it and studied it.” He said it was important to “check it out” before moving to a facility.

Table 4 presents the themes that emerged in the focus group at Site 2. One of the core themes to emerge was related to loss of independence. Other themes include health challenges as precipitating factors for the transition, psychological responses to the transition that suggest both a support and opposition to the transition symbolizing decline. Finally, the group members talked about the supportive factors in the relocation experience, which also can be seen as examples of positive aging.

Table 4

Summary of Intra-Case Analysis: Themes in Focus Group 1

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, and Subjugation**	**Examples of Positive Aging/ Supportive Factors**
	Ill health	Loss of Independence/ freedom	Feeling constrained / imprisoned by the transition	Focus on Self
	Desire not to burden family		Mitigation of the negative effects of transition	Maintaining current relationships
	Self-initiated decision to move		Surrender to the decision to transition	Creating new relationships
			Necessary acclimation	Involvement in investigation of facilities and decision making process
				Staff attentiveness as a support

Case-by-Case Analysis: The Residents

There were 10 older adults who participated in the individual interview portion of this study; one of these individuals also was part of the focus group. This section provides a detailed account of the transition experiences of the residents who participated in the in-

depth interviews. The four categories of themes used to organize the findings of the focus group interview also are used to classify the data from the individual interviews; however, a fifth category labeled "Other Themes" has been added to account for aspects of experience that do not fit within the four primary categories.

Individual Interview 1: Maureen

The time I spent with Maureen provided a powerful, insightful glimpse into the experience of the transition into assisted living. A number of themes, including isolation, loss of independence, role change and sense of uselessness, lack of adequate social connections, and importance of creating relational ties emerged in the interview with Maureen. These issues also surfaced in other interviews, but none in such a striking way as with Maureen.

I met Maureen on my second visit to Site 1 on a cool, autumn Sunday afternoon when she opened the door to the locked facility for me; she and another resident, Millie, were chatting in the lobby when I arrived. After introducing myself to the women and telling them a little bit about the study, I invited the two ladies to be part of an interview. Maureen instantly was interested and encouraged Millie to participate as well, saying "Come on, Millie! It'll be fun!" It was easy to see that Maureen was eager to talk to me, and I later understood that Maureen's eagerness symbolized a deep loneliness and isolation as well as a missing sense of purpose that characterized her life at Site 1—the intensity of which was almost unparalleled among the other respondents.

In the initial interchange in the lobby, the three of us had decided that I would interview Millie first, while Maureen took her breathing treatment. Before I could finish my interview with Millie, however, Maureen knocked at Millie's door and said to me, "I

just wanted to make sure you were still here and didn't leave without talking to me." In that moment, I became curious about Maureen's behavior as well as her statement. Maureen lived at the opposite end of the hall from Millie; she seemed to have quite a difficult time breathing; and she was on oxygen 24 hours a day. It took a concerted effort for her to walk from her apartment to Millie's room to seek out me —a stranger. She very much seemed to be looking for a personal interaction, and later, in the course of our interview, Maureen directly commented on her desire to talk to me. "I can't get out of here!," she said. "I was so afraid that you were going to leave this building this afternoon without coming here. You don't know what loneliness is until you come to one of these places. I mean I just want another human being that is intelligent to talk to and to be with. You cannot entertain yourself 24 hours a day." When I responded that there seemed to be a sense of isolation for her at Site 1, Maureen emphatically said, "Isolated…. Yes! There is an isolation. And I can call my friends, but you know they have lives. Most of them have husbands and kids nearby. And my kids are nearby, but they might as well be in Spain…."

Maureen was the youngest participant in the study at 75 years old, and she also was unique in that she had a graduate degree. She used her Master's degree in education to teach elementary school for a short while before discovering that teaching was not her passion: "I didn't like it. I was no good at it." In mid life, she went back to school to study accounting. After finishing her training in accounting, Maureen started her own business, which she thoroughly enjoyed, and the process of starting the business kept her from experiencing the empty nest syndrome. "I never knew what an empty nest was. I had it, but it didn't bother me a bit because I was getting ready to start my own business.

And I was, you know, getting my feet wet and I loved it. So, I didn't miss that." Working seemed to form a large part of Maureen's identity, as well as provide her with a sense of purpose, self-sufficiency and life satisfaction. All of these benefits of working underwent a dramatic change with the transition to assisted living. Commenting first about the community of older people who are sometimes forgotten in the aging process, she said, "Well, for a good reason. They have nothing to give anymore. You know you don't. You're useful years are over. They are. By all stretches." Then, reflecting on her situation in assisted living, Maureen said that with the move to Site 1, "I became more useless. At least I was self-sufficient where I was. I had that satisfaction of being self sufficient." Living at Site 1 meant "[t]otal uselessness. All you do is sit and stare at four walls. Either that or go to this pitiful little craft room they have where you take stickers and put 'em on buckets and boxes and tie ribbons. Dumb stuff."

Although Maureen had lived in Site 1 for a year and a half, she was able to recall the experience of leaving her home to move to assisted living quite vividly, because, as she recalled, "it was all just torn out from under me one day. And it was a shock." When describing the most notable change in her life since leaving her home and moving to assisted living she said:

> I don't know how to phrase it…(long pause)…I spent my whole life getting the perfect place to live and retire and I had to winnow down all the things I had to the precious few, and everything had significance—everything. And…I was on one floor, no steps anywhere. I could go outside, no steps. And all of a sudden this happened and I had to leave it all. I had to sell things, and my kids were snatching things, and it's just…and it just felt like they were tearing things off ME. I mean

they were things I had loved all my life and things that had belonged to my grandparents. Just gone. I mean, sold at auction for nothing. And it just killed me. And we should never be so attached to things. You don't love nothing that can't love you back—things don't love you back. I just...(pause)…it's one reason why in here I've got a lot of things that were my grandmother's. That was my mother's (points to some wall hangings). Interesting things…and all the pictures on the wall have significance.

While Maureen experienced the transition as a "shock", she, like many of the other residents, made the decision on her own to enter assisted living. Her decision to move was prompted foremost by health-related reasons. She suffers from a chronic lung disease that affected her breathing and her ability to take care of her home. "…[T]hat's why I'm here…cuz I couldn't handle my house anymore. And the help was hard to get and unreliable…and you know, transportation was ouchy…and it was just easier." Also underlying the decision was the reality that she wanted to make this decision rather than allow anyone else to make it for her. Taking responsibility for herself and her ailing health also was reflected in her work life. "I knew I had to quit the job. We used to laugh about the old people working in this business and some of them needed to go home. And I thought I don't want to be one of those. So I quit before I became the butt of jokes. Get out before they kick you out." She left her work while she still had her "dignity", and soon after decided to move to Site 1. Yet, assuming the autonomy of that decision to sell her home did not ease the pain and shock of the actual move. "To actually get that moving truck and see that stuff go out of that house just…(pause)…it was awful, it was awful. Just terrible. It's a void in your life."

Trying to comprehend the pain and difficulty of leaving her home, Maureen confirmed that part of her identity had been tied to her home. She reflected on the meaning of her own home through a description of her mother's house: "She had this farmhouse down in Virginia that was built in 1792. And it was the most inconvenient building on the face of the planet. And she loved it 'cuz it was home. And all you did was walk in that place—up stairs and down. It was awful, but she stayed in that place till she was 91 years old. She would not hear of moving. It was home."

One of the other factors that made Maureen's transition to assisted living so difficult, and that contributed to her feeling of isolation, was her inability to connect socially with the other residents. A self-described "loner" who didn't seek out other residents when she first moved to Site 1, Maureen said, "I've had trouble finding a social match, somebody with a real good sense of humor." She believed that one of the sources of incompatibility was "socio-economic background and education. They [other residents] don't read the morning paper except for who was murdered. You know there are more significant things in the world than that—and tomorrow's weather…(pause)…I miss an intellectual interchange."

Another area of disappointment related to the transition that a number of other participants talked about was with regard to the food. She reported that, "I will not eat their food down there at five o'clock. So, I struggle with dinner in my room." Maureen talked despondently about wanting some kind of food that "did not come out of a can." She asked me, "Did you ever eat asparagus out of a can?" When I hesitantly admitted no, she said, "You never want to…."

There were a couple bright spots, however, in Maureen's social life. She still met monthly with high school classmates and with them, she said, "there is always a discussion there that has some meat to it." Additionally, Maureen struck up a friendship with Millie, a resident who had moved to the facility several months ago and with whom she was talking when I had arrived. She was deeply appreciative of Millie's sense of humor: "She has it…she has it….and we laugh." Getting to know Millie "has made a lot of difference" in her life at Site 1, Maureen said.

Another part of Maureen's experience that consistently was described by other residents is the loss of independence. As she talked about the impact that her decision to relocate to Site 1 had on her relationship with her children, Maureen said, "I think they feel relieved that now they don't have to pay any attention to me because now I'm off in …locked up somewhere, and they know I'll get three squares a day." When I remarked about her choice of words "locked up," Maureen said, "Well, I can't get out." And, when I specifically mentioned that I had heard older adults call assisted living a prison, Maureen said, "Yeah, it's the same as a prison. You can't get out." She then referred to the person who had telephoned her during our interview and said, "That phone call there was my method out. She drives my little red car sitting out here...She's my freedom." The issues of freedom, independence and the metaphor of assisted living as prison surfaced in other interviews, as well.

Despite the many barriers to making a good transition to assisted living, Maureen was able to identify some factors that enabled her to continue getting by. Common to other residents, her financial status was a plus. "I have enough money to afford it. It could be a lot worse." Beyond her financial security, Maureen talked about facets of her

own inner resources—her attitude and her decision to go on in spite of hardship—that were echoed by other respondents . “I think back on people in my family that have had adversity, and they bit their tongue, and they say it could be a lot worse. Shut your mouth and row. You’re not here to be entertained on this earth. Your job is to be as little trouble to other people and as much help—in my view. But, you’re certainly not to cause other people trouble. So if you’ve got problems, it’s your problem and nobody else’s.” She also mentioned that having caring staff at the facility was important and that it had “made the adjustment a lot easier. These girls here are wonderful. The staff here is amazing. They are wonderful people.” She was especially grateful for two women who “had that way of coming into a person’s room and you know it’s going to be ok. And just sitting down with you and laying on of hands.” Finally, with a bit of humor that she so cherished, and with a touch of sarcasm, Maureen reflected on the advantages of moving into the facility: “I knew if I fell, there would be somebody here that I could call. If they’re not busy serving dinner, they’ll come and pick you up off the floor….”

Table 5 provides a summary of the emergent themes in the interview with Maureen. The themes are organized according to the social constructionist framework of aging in western culture. Other key themes that did not fit within this structure but that are part of Maureen experience are also identified.

Table 5

Summary of Intra-Case Analysis: Themes in Interview 1

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging / Supportive Factors**	**Other Themes**
	Ill health	Loss of independence/ freedom	Surrender to the decision to transition	Focus on Self	Dissatisfaction with food
	Desire not to burden family with care-giving duties	Role/Identity Change (Sense of uselessness)	Decision accommodates children	Forming new relationships (with staff and other residents)	
	Self-initiated decision to move	Physical decline	Feeling constrained/ Imprisoned by the transition	Maintaining existing relationships	
		Withdrawal from the wider community	Stereotypes about aging process / older adults (elders seen as useless and unproductive)	Community involvement outside of AL	
		Sense of Isolation		Economic stability/security as a support	
		Loss of valuable/meaningful items in the move		Staff attentiveness as a support	
		Lack of social relationships within the facility			
		Lack of activities that meet intellectual or social needs			

Individual Interview 2: Emily

At age 98, Emily, a widow of more than 25 years, was the oldest of the participants in this inquiry. Having lived at Site 5 for 5 years, she also had been in assisted living longer than any other participant. When I met her for the interview, I was surprised to learn her age and would have guessed that she was years younger. There was no wheelchair in her apartment, and most of the time she only used a walker when she

went to the dining room or out of the building. Her white hair was fixed attractively, and she wore a matching top and pants outfit accented with a broach and earrings set. Like her appearance, her apartment was carefully attended to; it was filled with simple but tasteful furnishings. During the course of our conversation, Emily told me that the directors at Site 5 had used her apartment for several years to show potential new residents. At the close of the interview, I left impressed by her energy, good sense of humor, and strong will and determination.

Emily and I began our conversation by exploring her initial impressions of the transition to Site 5. Reflecting back on the first weeks and months of the move, she said, "It was horrible. I didn't want to leave home. When I died, I wanted to die at home." Although a significant period of time had passed since Emily had moved to Site 5, the transition experience seemed to touch her as deeply five years after her relocation as it did during the initial phase of the transition. She wanted to forget the painful aspects of the transition: "It's like water over the dam. I should forget it," she said, and emphasizing her point, she later stated, "I should forget it and live with it." However, the power of her words suggested that indeed she had *not* forgotten and that the transition experience continued to be a part of her life.

One of the most prominent themes to emerge in my conversation with Emily was related to her greatest loss—the loss of independence. Grounded in the shared retrospections of other residents who participated in this inquiry, Emily's experience was not an uncommon part of the transition to assisted living. She peppered the interview with references to lost freedom and independence. "I have no independence. I have to do as I'm told to do—when to do it." Taken by her statement, I shared, "That's a powerful

statement that you've lost your independence—that you don't have freedom." Emily said in reply, "Completely. Completely. You don't have none…You have to sign in and sign out when you come in and when you leave the building." In one colorful metaphor Emily described her experience this way: "Well, I don't have liberty. I'm not free. It's just like a child going to school. If they want to go to the toilet…(laugh)…they don't get up and go…they have to have permission to go." The most powerful metaphor Emily used to talk about the loss of her independence was through a rich description about the impact of losing her home. "They sold my house. That was another sad….that was the saddest day of my life, when they sold my house. I wouldn't speak that day. My family knew I was mad. It was like a death." For nearly a half century, Emily and her husband had lived in the same house. She recounted happily that her husband used to come home at the end of the day and call out, "I'm home! Home sweet home!" "I could hear him every day. He loved our home," she said. "And you, too…?" I wondered. "Oh, yeah…45 years that's a lot of our lives. That's the longest I lived in one place." Inquiring further what her home meant to her, Emily declared, "It meant freedom. My own way of living." Losing her home, Emily said, "…just changed my whole life. I'd been independent my whole life. Even when I was a kid, I was an independent kid. And they took my independence away…In other words, I lived according to the way *they* wanted me to live, not the way *I* choose to live." Even after five years in assisted living, Emily's home was still present to her. "Everyday I think of that house…(pause)…I think of the kitchen, and I think of the neighborhood." With the deeply symbolic meaning that Emily's home held for her, I wondered: How did she come to leave it and relocate to Site 5…?

For Emily, as for many other interviewees, the transition to assisted living began with health challenges; she had had a series of falls in her home. “I used to fall a lot at home, when I was doing work or something,” she said. The last, most serious of the falls required her to be admitted to the hospital and later to a nursing home for rehabilitation. Subsequent to the last fall, Emily’s daughter and the medical professionals at the nursing home decided that Emily should no longer be living at home on her own. At least two other participants in this inquiry also talked about decision making processes in which adult children, medical staff or other influential people made the decision for them about relocation; Emily was the most vocal opponent of this process. As reflected in the following segment of our conversation, Emily described the experience of being left out of the decision making process surrounding her relocation:

> CJ: But that was the rationale about why you couldn’t go home—because you couldn’t get dependable help at home?
>
> Emily: Uh huh...that was the main …that was the main subject they kept putting in my mind, but I didn’t feel that way about it.
>
> CJ: How did it happen that nobody listened to you?
>
> Emily: That’s what I haven’t been able to figure out….
>
> CJ: Somehow other people convinced you that this would be the better…was your voice heard when they made the decision?
>
> Emily: I had nothing to say. Anything I said, they bucked it. I didn’t want to come here. Now, it’s true when I fell in the tub…I hit the back of my head and I split it….I don’t know how long I laid there. I was just lucky enough that I was able to call for help…That’s when she decided I was not going to be at home.

CJ: You said, *she* decided…?

Emily: Uh huh...her and the nurse.

CJ: I wonder how you got pulled out of that picture? You're the person who's having to make the adjustment and a medical professional came in and probably talked to [your Daughter], and she was probably scared for you and somehow it was…I wonder if it felt like they were working together against you?

Emily: Uh huh...That's the whole thing...yeah. And another thing that was done that I would give her power of attorney. Even the priest talked me into it—giving [Daughter] power of attorney.

According to Emily, a number of influential, even powerful, figures in her life, including her only daughter, the nurses at the nursing home, and a religious leader, believed she more likely would receive the dependable care she needed in assisted living than in her own home, where she would have received assistance from a community agency. Not being heard during the decision making process about how to receive the best, most dependable care noticeably was part of Emily's experience.

Another theme that emerged for participants in this inquiry with which Emily readily could identify was the experience of being restricted, confined, and even jailed. At the outset of the interview, Emily declared:

> When you live alone all your life, well, not alone, but when you live at home, I did what I wanted to do when I wanted to do. But here you can't. You're on a schedule. For instance, you can't stay in bed. You have to get up. They have rules. In other words, you change your whole life. A way of living—what you're accustomed to. You live according to what their rules are. You lose your own.

Emily talked about feeling restricted with regard to dining experiences and procedures related to medications. “If you don’t come in at a certain time, you’re out of luck. I mean for eating…for the eating schedule. And for medication, you take the medication when the nurses give it to you.” Later, she spoke generally about the sense of being confined to the rules of the assisted living site: “My whole life has changed…(pause)..and they say it’s so wonderful to live here. I don’t know about that. They say it’s supposed to be happy that you live this long. It seems to me the longer you live the more miserable you are.” As I probed Emily about the source of the misery, I wondered aloud if it was related to her sense that other people tell her what to do, and she responded, “Yeah, you don’t have any say so. It’s just like going back to a child. But, I don’t do everything they tell me to do….” Another way in which Emily felt suppressed was related to her experience of time. “Their time is their time, not my time.” Finally, I shared with Emily that other interviewees had compared the transition to assisted living with being locked up or in jail. Emily enthusiastically agreed, “It is! I always said this is a first class jail! Yeah, I says, it is a first class jail.” To try to understand more deeply how she experienced Site 5 as a jail, I asked Emily to tell me what that meant to her. “Well, it’s all dressed up, but you eat when they tell you to eat, when they tell you to go to bed, when you get up… And when you in jail, they have rules. At a certain time you come in and they all march ‘em in there to eat…and the food—they call it slop…only this is done in a delicate way.” A very tangible part of Emily’s experience of transitioning from her home to Site 5 was embodied in the metaphor of assisted living as jail. Even in the way she talked about her relationships, Emily made a clear distinction throughout the interview between herself and “them”. She talked about “their time” versus “my time”, living as “they wanted” her

to live rather than the way "I choose to live", and living according to "their rules" not "my own." These expressions of division between her own desires and those of what Emily called "officials" at Site 5 suggested a power differential in which she saw herself as less powerful than the administration and staff on site.

Also part of Emily's experience was a sense of isolation that seemed to have become more prominent the longer she lived at Site 5. "…A lot of the people that were here…have passed away. The people I was accustomed to. Now, I hardly know any of the people. New ones coming in and I don't know 'em. And I stay in my room more. I never stayed in my room like I do now. I used to get out and mingle. There were a bunch of people and we'd laugh and we'd do things and all, but that's out the window." I asked if that contributed to an increased sense of loneliness or isolation and Emily confirmed, "Yeah…in here…yeah." The impact of having witnessed the deaths of many of her close acquaintances in Site 5 also had taken a toll on Emily. "It's terrible," she said, "all you think about is dying. I just don't want to mingle and meet new people anymore. I would rather be in here."

Emily and I talked about how relocation had affected her relationship with her family. In one sense, her family was a support to her. Her daughter tried to take her out to lunch at least once a week, which Emily very much looked forward to. Additionally, to the degree that her family was aware of her unhappiness at Site 5, they tried to respond. "She [Daughter] knew I wasn't 100% here, and she says 'Mom, you can move to another place,' and it would be lots cheaper than what I'm paying here. But I didn't want to move again. I despise to move." Emily's daughter also spoke to the staff on Emily's behalf to request adjustments in some of their nursing procedures that would better fit Emily's

needs and lifestyle. At the same time, there was a part of Emily's relationship with her family that uniquely reflected a facet of the theme that other interviewees expressed about not wanting to burden their children. "I don't express to [Daughter] how I feel. She's got enough to worry about herself. I don't want to add more to it. It's not going to help. What ever has been done is done. I should forget it and live with it. I do live with it, but I don't express it to my family." Later she said, "…I don't want to cause any friction in the family. I don't want them to know how I feel or what I think about." Finally, she said, "I don't want to hurt them. They thought they did something wonderful for me." While a number of other residents moved to assisted living to prevent their children from dealing with the daily care-giving responsibilities, Emily talked about not wanting to burden her family with the full revelation of her unhappiness at Site 5.

Another risk factor that uniquely was part of Emily's experience related to anxiety about her financial situation. Having lived at Site 5 for 5 years, Emily was acutely aware that she soon will have spent all of her savings. "The money: they're draining me out of my money. [Daughter] says I got two more years, and I'm gonna run out of money. So how do you think I feel? Am I going to wind up in a nursing home? A lot of people here, if they live long enough, they send them to a nursing home, and they're not there very long until they die." I asked Emily about the impact this knowledge had on her, and she stated, "Right now, that's hurting me very much because I don't sleep as well and I'm very concerned." The situation, in Emily's perspective was "getting worse" with time. When she first relocated, she said, "I might have lost my independence, but I didn't loose everything…and then I felt safe because I figured I had enough money to take care of me." With the passage of time and the expenditure of her funds, Emily said, "they're

taking my furniture, my money…and I used to donate to the church…felt free to donate…and now I don't have it to give."

Another peripheral issue that Emily mentioned that also arose for a few other residents was related to dissatisfaction with the food at her facility. "It's no home. They must be kidding! No, it's not your home. And, uh, they…I know it's rough to try to satisfy everybody as far as food is concerned. The food is different. It isn't the way you want it. It's different completely from the way you prepare it. And they tell you you have a variety to choose from, but even the variety is nothing I want!" Emily also noted that she weighs more now than she has in her whole life and attributed her weight gain to a diet high in carbohydrates and low in fresh vegetables and fruit.

Finally, one of the other interviewees, Maureen, touched on the idea that the transition to assisted living brought to the fore some myths related to the aging process and older adulthood. Emily also touched on the topic of cultural myths, and, in an example about the types of activities the facility offered to her and other residents, she specifically addressed the stereotype that older adults are senile.

> They have different things they do, and it reminds me of being in the kindergarten. I'm not interested in that kind of stuff that they do. Crocheting or making a little doll or something. I'm not interested in that! I don't want to waste my time. I'd rather sit here and raise hell!!...(laugh)…I call it simplistic…they treat us like we can't think…just cause we're old doesn't mean we're senile!

I connected with Emily's statement and mentioned that it seems that it is easy for people to think that once an older adult has a physical health challenge that adult also loses his or her mental faculties. In agreement, Emily said, "Yeah!" and proceeded to recount an

occasion when she had been in the hospital and her grandson had "tested her" by asking her various questions. "I didn't like the idea of them testing me. Asking me questions like: Where am I? Where in the hell do you think I was? He thought maybe, you know, I was kind of out of it because I had been in there so long, and I could tell the kind of questions he was asking that he was testing me, and I didn't like the idea that he was trying to test me. I was way ahead of him!"

Throughout the interview, Emily spoke powerfully about the transition experience and easily was able to voice her dissatisfaction about life in assisted living. Emily struck me as a woman of great passion and strong will who likes to laugh and, as she good naturedly told me, "raise hell". Similar to other participants, loss of independence surfaced as a core theme for Emily. A number of other themes that resonated in the experiences of other residents also emerged, including health challenges as a precipitating event to transition, the sense of being confined or restricted by life in assisted living, and the desire not to be a burden to family. Table 6 provides a summary of these and other themes that emerged in the interview with Emily.

Table 6

Summary of Intra-Case Analysis: Themes in Interview 2

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging/ Supportive Factors**	**Other Themes**
	Ill health	Loss of independence/ freedom	Not being heard in the decision-making process of relocation	Focus on Self	Greater awareness of death
	Desire not to burden family	Desire not to burden family (with negative feelings about the transition)	Decision accommodates children	Forming new relationships (with staff and other residents)	Dissatisfaction with food
		Physical decline	Feeling constrained/ Imprisoned by the transition	Maintaining existing relationships	
		Decreased involvement in the wider community	Stereotypes about aging process/ older adults (elders viewed as senile)	Family visits and involvement as a support	
		Sense of Isolation			
		Loss of valuable/meaningful items in the move			
		Economic instability as a cause of anxiety			
		Lack of activities that meet intellectual or social needs			
		Lack of social relationships within the facility			

Individual Interview 3: Rita

Rita, a plump, white haired, 90 year old woman who has lived at Site 2 for a little more than 2 months, participated in the focus group and later also agreed to have an individual interview with me. Prior to her relocation to Site 2, Rita resided in a condominium, and since the death of her husband 25 years ago, she had taken care of herself and gotten very used to being independent. “Living alone 25 years, you get pretty

independent," she remarked. When asked if the decision to move to Site 2 was precipitated primarily by a health concern, Rita replied, "No, no, this [gout] is the worst thing I've had for many, many years. I don't get colds or anything." Rather, the decision was related more to the simple fact of her age, as well as her children's concerns for her well-being. "The children feel easier. It was just the idea of driving on snow and ice in the winter, which I would probably do if I were out. The children, I know, felt like it was time for me to quit driving in the winter." Rita is the mother of seven children, including six boys and one girl. Two of her six boys are dead, two children live in Central Ohio, one son lives abroad, and the rest live out of state. Although one son who lives in the Midwest invited Rita to come to live with him, she did not want to impose herself on her son. Rita stated that her own mother had lived with her and her husband for over 20 years and although they all had gotten along, she was familiar with the experience of caring for a parent, and she did not want to impinge on her children's independence.

During the focus group and again in the individual interview, Rita expressed that the most difficult part of her adjustment was related to the issues of loss of freedom and independence: "The only thing I miss is my freedom." Specifically, for her the loss of freedom was symbolized in having to give up her car. "I had a lot of misgivings about coming here, that's for sure. Especially when I realized that you couldn't have a car." That takes away your freedom. That's the big thing." I recalled a statement she made during the focus group and remarked to her, "When you first moved here you said it was like being locked up…I am wondering, what is that about?" Rita replied: "Because you don't have your car. To me it would be like living in an apartment, except you have your meals. If I knew I couldn't have my car, I probably wouldn't have done it yet."

After only two months of living at Site 2, Rita described herself as fairly well adjusted to the transition and was able to identify a number of resources that aided her in the adjustment process. First, she made the decision to move to assisted living on her own. When asked about the level of input from others in her decisions, especially her family, she said, "Not too much was said. I made the decision on my own." In addition to the fact that she had made an autonomous decision for the relocation, Rita, like a number of other interviewees, also said that her financial stability made the transition easier. Although Rita herself had not gone to school beyond high school and did not work outside of the home after her children were born, her husband "had all the brights" and eventually worked his way into the position of vice president of a large company. She described herself as "well provided for" and said, "I put away a sum for my care, and that's a blessing that not everyone has. It just so happens that my husband had a good salary and he was a very good money manager. I don't have any worries about my finances. That is a REAL blessing."

Another factor that Rita described as being an advantage to her during her adjustment was a history of facing adverse moments with an attitude that she had to figure out ways to journey through the struggles. "Well, I learned long ago that you have reversals, such as my husband being taken and my dad was killed when I was ten, so you learn to go on." In the same vein, Rita espoused a perspective that change inevitably occurs in life and that adjustment to change is a normal process. Of a relocation she made earlier in life she said, "I came from the West. I came from [City] and I got homesick, but you get over that." Then, describing her initial reaction to the relocation to assisted living, she reflected:

> The first few days I kind of panicked a bit—just struggling with myself about the whole thing. But, with any big change you're going to have that. Any big change you have to get accustomed to. You can't look back, that's the whole thing. You can't look back, you have to look forward. I'm never going to be young again. I'm going to get older if I live. And, I'll probably get feeble if I live long enough. This is a good place to be for old people. I recommend it!"

The biggest resource throughout the entire process of deciding to relocate, moving, and settling into Site 2 that Rita identified, though, was her faith life and her relationship with God. "I can tell you the best part. Knowing the Lord is your Savior. I've known the Lord for 80 of my 90 years. Never doubted. That's the best thing of all." When asked specifically how that had an impact on her transition to assisted living, Rita emphatically replied, "I know the Lord is over everything that I do. Always has been. And, if that's where he would have me, that's where I want to be. You ask the Lord for guidance and if this is where you are guided, then you know it is for the best. I don't have any doubts; I don't have any fears."

Although Rita said she was "at peace" with the decision to move to assisted living, she also made a number of comments that suggested that the living through of her decision to move still was a struggle and that she was working through some resistance to her decision. "The children are at ease that I'm here. That doesn't mean I wouldn't rather be out in my condo with my car!" And later, "I made the decision, but I do the things after asking the Lord's guidance. It doesn't mean you don't have doubts and ups and downs." And finally, "I don't think most people come in because they see this as a great

way to live. They come in because it's a sensible way to live. And, it's proving to be that."

During the interview with Rita, I had an opportunity to ask for more information about a possible theme that emerged in another interview related to death. When I wondered aloud if the transition to assisted living made the reality of death more present, Rita stated, "I don't think so, it just changed my lifestyle. Because I'm sensible enough to know that's old age, any way you look at it. It wouldn't be my choice of a way to live if I weren't old. Let's put it that way. But, being you can't change that I've lived 90 years, and you can't change it, and I'm grateful that I can have a good place to live. I'm just thankful for it."

Table 7 provides a summary of the main themes that surfaced in the interview with Rita. Among the units of meaning that emerged are precipitating factors related to a desire not to burden the family and a self initiated decision to move. Biopsychosocial issues included loss of independence and withdrawal from the community. Rita also talked about the decision to move as a sensible choice, but one by which she felt constrained. Finally, themes related to positive aging experiences included, focus on self, maintaining relationships, financial stability, and faith as a support system.

Table 7

Summary of Intra-Case Analysis: Themes in Interview 3

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging / Supportive Factors**
	Desire not to burden family	Loss of Independence/freedom	Surrender to the decision to transition	Focus on Self
	Self-initiated decision to move	Decreased involvement in the wider community	Pressure to Adjust (family)	Maintaining existing relationships
			Decision accommodates children	Forming new relationships (with staff)
			Feeling constrained/ Imprisoned by the transition	Economic stability/ security as a support
				Spirituality/faith as a support

Individual Interview 4: Jacob

Jacob is a 77 year old resident at Site 1 and one of 10 men out of 44 residents at his site. However, when he first moved to Site 1 three years ago, he was one of only three men there. I first met Jacob in his room at Site 1, which was filled from corner to corner with furniture, appliances, a large screen television, stereo system, papers, magazines, and books. In the midst of the many things in his quarters, Jacob, who was in a wheelchair, navigated quite well through the crowded space. He was just about to fix himself a late lunch when I arrived, but with great hospitality, invited me to sit down and talked willingly about the process of transitioning from his home to assisted living.

According to Jacob, the transition "was not hard because my wife had died, and I was living alone." The death of his spouse seemed to be the beginning of a change in Jacob's life and the first challenge to his independent lifestyle. In reference to his children, Jacob stated thoughtfully, "They said I could not make it by myself…I had a feeling that I could." Having made this decision about his abilities, Jacob attempted to maintain his life at his home by enlisting outside help from the community, but

eventually, he encountered numerous health problems that were difficult to overcome. "I started at home at my house and I had somebody come in twice a week, and she would do my laundry for me and clean house a little bit and feed me a couple meals. But I did most of the meals myself…She was a regular person who did this, now. She worked for an agency." When he finally decided to move to Site 1, he said, "I had had several operations and wasn't in the best of health, then, but still, I needed help." When I asked him if the health concerns were part of the reason he decided to move out of his home, Jacob declared, "Yes. Exactly." Like many of the other residents in this inquiry, his transition to assisted living ultimately involved health challenges that he determined he could not overcome while living on his own.

Because Jacob was not among the first interviewees with whom I had met, I had the advantage of having reflected on the experiences and stories of several other residents when I spoke with him. We talked about some of the barriers or difficulties to the transition process, and specifically, I asked him about the loss of independence that other residents felt was one of the hardest adjustments to make. He agreed, saying "Yes, that's true. I'll go along with that." One of the ways that Jacob felt constricted was through a process of signing in and out of the facility that was required of him and other residents at Site 1. "You have to get permission to leave the building," he shared. When I asked if it was a struggle to adjust to that, he admitted, "Not really," and then reflected, "I just don't like it. I don't think anyone does. I'm an adult. I think I can take care of myself." Another theme that emerged in other interviews was related to the experience of isolation. When I asked if he, too, felt isolated or cut off from the community, Jacob stated, "Uh huh…a whole lot." One of the things he missed was his network of friends that he left behind. "I

did leave a lot of friends back there. I had a lot of friends back there in [city]." Eventually, we discussed the actual day of home-leaving that he undertook in preparation for moving to Site 1. "It was horrible," Jacob testified. "They [the children] told me, 'Sit down.' I didn't get to do anything. I didn't get to go in the basement and look at anything in the basement. I'm a saver…look around [at the room]…that day was not pleasant."

Jacob was one of four men in the study and one of two men with whom I conducted individual interviews. I was curious about the role of gender in the transition and adjustment process. Jacob was quite aware of the gender difference. "Out of 44, there are only 10 of us men," he said. When I asked him if he thought this difference had an impact on the activities that were planned, he stated that he noticed the difference, but it did not appear to have a significant affect on his involvement in the life of the community. "Crafts I don't participate in," he said, "but that's about the only thing I don't do." Moreover, Jacob seemed to see the gender imbalance as an advantage. "I'd rather live with women, I think." A moment later, he said, "It's funny, because it's mostly women, but I think they take care of themselves. They handle things better. I think women handle death better. I was shook up, boy, when my mother died. I was pretty close to her…(pause)." With this reminiscence, Jacob changed the subject to a lighter topic….

A theme that subtly emerged in Jacob's story was related to the factors of power and autonomy. Other interviewees mentioned that they felt locked up or as if they were imprisoned in the assisted living facility. When I talked to him about their experiences and asked him if he shared a sense of "being in prison," Jacob said, "No, I didn't feel that way at all. I just needed to make a move." However, Jacob did make references to the

"upper echelons" that were responsible for his care and that required him to sign in and out of the facility. Later, in a more striking fashion, Jacob talked about what happens when he falls in his room and how that can have an impact on who decides if he needs greater care, and subsequently, an alternate placement. "If I fall," he said, "they're there to help me out. Sometimes I don't tell them, though, because they record it if you fall, and if they see it too many times, they'll ship me someplace else. So I just don't tell them." To get clarification, I asked, "Do they have the right to make some decisions for you, then?" "Yes, I think so. They just send you out someplace where they hold you like you're a patient—where you have to be tended to 24 hours a day." The reality of the relationships with caregivers and management within which Jacob lived appeared to be marked by a certain tension. On one side, he stated, "The people here are really great. They help me out in any way that they can. In the cafeteria, they're more helpful than anyone else." At the same time, though, Jacob hinted at a clear power differential in which others—perhaps facility directors or managers—had the ability to make decisions about his future placement should he require it based on health challenges.

One of the most prominent things that emerged in my interview with Jacob was a set of themes that pointed towards various aspects of positive aging. Although Jacob said "I consider myself an isolated individual," he provided ample examples of his involvement in the life of the assisted living community, efforts to be integrated in the wider community, pursuits for his own pleasure, and significant relationships in his life. First, Jacob described the activities at the facility: "We have all kind of entertainment. Some of it comes in. Some of it we go out for. We go out once a month for a movie. They take us to that. I take advantage of all of it. I think you're crazy if you're here, and you're

paying for it, why not go?" He also talked about maintaining a connection to the "outside world." "I get out enough. Every week I go to [grocery store] even if I only buy one thing." During previous years, Jacob arranged for the custodian of the facility to take him to a high school football game at the school where he used to teach. "This is the first year I haven't really gotten to a game. The custodian here will run me down to a game if I want to go down. One of them is coming up next Saturday. I may ask him to take me down," he mused. Jacob also attends some of his granddaughter's high school basketball games. "They make sure I get there, my sons do." On another occasion, he went fishing at a nearby lake with the facility director and her husband. "I don't fish, but I like to watch," he said. In some sense, the "outside world" even came to him. "I have the Schwann man come," Jacob reported. "I'm the only one in this place that has him.…" On another level, Jacob continued to pursue avenues of personal interest after his relocation to Site 1. "I like to read. I'm a nut about the Civil War and World War II. I subscribe to about 5 magazines. See this book, D-Day? I started that book. I love Ambrose—Steven Ambrose. He writes just the way I like him to write." Jacob also shared that he recently engaged in a new hobby: "I took up photography. I got a camera that cost me a 1000 bucks, but I wanted it that way because I wanted it to do everything. I told the guy I want a good camera." In some cases, the transition afforded him new opportunities, such as meeting spiritual needs and growth. "I go to church, which I wasn't doing in a long time. I'm now going to bible study which I wasn't doing before. It's great." Finally, Jacob talked about his relationships. All four of his sons live close to Site 1, and when I inquired whether or not he sees them often, Jacob said, "Yes, as a matter of fact, one of them was here yesterday." Moreover, he formed a significant relationship with another

woman in the facility. “I have a woman, well, she’s a resident here. Boy, she’s helped me out a lot. She’ll lay out my clothes for me. She and I just got friendly. She lost her husband.” Later, he was more specific in describing the relationship, saying, “The girl…my girlfriend, well, I guess she is my girlfriend. She was lonely when I got here. We got along famously. And what happened was that I asked her to keep my books for me. I had trouble writing anymore, so she would keep the books for me. Do my business and stuff. Write my checks.” Finally, when I wondered aloud how the staff responded to Jacob’s friendship with his girlfriend, he disclosed that the staff had “not said a word” to him. “Nothing’s happening,” Jacob said, “except I ask her to sleep with me and she’ll sleep till midnight and then get up and go home. Nothing’s happening. I just like someone to sleep with…. We talked about marriage, except she’s got some money and I’ve got some money that I want to save for my kids and that could make things complicated, so we both decided not to.”

In trying to make an accurate interpretation of the social and relational aspect of Jacob’s life or to more deeply understand how he continued to engage life throughout his transition from his home to assisted living, I returned to one statement Jacob made about the visits his children make to him. When they come, he said, “They don’t stay long. Heck, I don’t blame them. I’m an old man. To me I’m not, but…(pause)…I’m 77, but I don’t feel like it.” Maybe in Jacob’s case the cliché is true: A person is only as old as he feels.

Table 8 provides a summary of themes from the interview with Jacob. The most prominent biopsychosocial problems that Jacob identified are similar to those that other interviewees mentioned and included health challenges, a sense of lost independence, and

isolation. Jacob also touched on issues related to power differences and cultural stereotypes about older people. Finally, Jacob had found ways to utilize available supportive factors and engage in positive life affirming activities such as forming new relationships, starting new hobbies, and getting involved in the community inside and outside of Site 1.

Table 8

Summary of Intra-Case Analysis: Themes from Interview 4

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging / Supportive Factors**
	Ill health	Loss of Independence/freedom	Surrender to the decision to transition	Focus on Self
	Desire not to burden family	Decreased involvement in the wider community	Decision to move accommodates children	Forming new relationships (with staff and residents)
	Self-initiated decision to move	Physical decline	Feeling constrained by the transition	Maintaining existing relationships
		Sense of isolation	Fear that future placement decisions will be made by others	Community involvement inside AL
			Not being treated as an adult	Spirituality/faith as a support
				Economic stability/security as a support

Individual Interview 5: Walter

Walter is a 77 year-old, slightly handicapped widower who has been a resident at Site 3 for the past year. Walter graciously invited me to join him for lunch at the site before I met him for an individual interview, and I had the opportunity to enjoy a meal with him as well as another resident and her daughter. The lunch conversation was very much centered on Walter's and his table partner's involvement in activities in the wider community. My impression that Walter made a concerted effort to maintain his community ties was confirmed in our individual interview. In a very transparent and

simple way, Walter shared his experience of transitioning to assisted living, which in his case, has been a move that fulfilled a number of important needs and has served to provide greater advantage than disadvantage.

Before his wife, Lynn, died a little more than a year ago, Walter and Lynn had been contemplating moving to assisted living. Lynn had been in and out of the hospital with a terminal illness and Walter, who is handicapped as a result of a childhood illness, was struggling with day-to-day activities that were part of keeping up a home, especially meal preparation. Like some other interviewees in this inquiry, he was involved in the decision making process to relocate. "Just about the last time she went in the hospital, we were just about to the point that we were going to come over here and talk to 'em and see what was happening. Because we had gone to the other one in [Town], and it was so expensive that I said let's not do that if we don't have to. There's got to be some place that's a little cheaper than that." As his wife's illness became more severe, Walter and his sons eventually put his name on a waiting list at Site 3 so that he and his wife could move in if she was well enough to leave the hospital. "If she got out," Walter reflected, "she wouldn't be able to keep house and we'd just move in over here." However, "she didn't live long enough to know that my name had come up," Walter said. Four months after his wife died, Walter relocated to Site 3.

When I asked Walter to describe the transition he stated, "Under the circumstances, I knew that I was not ready to live by myself because it's just like I said, I didn't cook at all. Cause even when Lynn was in the hospital I'd eat breakfast at home and that was it. And I'd either get something there at the hospital or I would go out. And the boys, one or the other of them, was always coming to the hospital, and they'd bring

something or we would go out. But most of the time we'd eat at the hospital." Walter mentioned that his wife had always taken care of the home as well as prepared all the meals when she was well. On a practical level, Walter was well aware that he would face a challenge in the taking care of the home when his wife passed away, and he did not know if he wanted to respond to this challenge. Later, when he described the advantages of living at Site 3, Walter said of the assisted living staff, "They took care of my cooking and house cleaning. The cooking I needed but the house cleaning I could have handled but…well I could have, but I just didn't!"

Although well aware that relocation was something that he wanted, Walter, like other participants, described the initial transition period as "lonesome." "[Y]ou're sitting here with nobody to talk to," he said, and then mused, "…thank goodness I had television." The sense of loneliness for Walter seemed to be multilayered, part of which was related to having left his neighborhood community and home and moving to a place where he was not acquainted with the other residents. When I asked if the transition was difficult, he said, "Well, it was when I first moved in because I didn't know anybody." This sentiment was echoed in the testimonies of other interviewees. However, Walter also connected the sense of being lonesome to the loss of his wife. In talking about the most difficult parts of transitioning, Walter said, "Just the fact that we'd been married so long and it was hard to break up and think, you know, that I'm now alone. I never expected with my condition that…I figured she'll outlive me. I was more or less surprised when it happened. I just accepted it because I figured, well, there wasn't anything I could do about it. So, I guess I handled it the best that I could."

Another theme to emerge in Walter's experience that also was evident in experiences of other participants was the difficulty in relinquishing his car and having to rely on other people for transportation. "The biggest thing was giving up the car," he stated. When I asked him if the car was related at all to his sense of independence, he said, "Yeah…I used to do all the local driving." In a very matter-of-fact way, Walter wondered, when he gave up his car, "Gee, now how am I going to get any place?"

Aside from some initial difficulties, Walter described a number of advantages that assisted living afforded him; in many ways, Walter appeared to embody an example of an older adult engaged in a positive aging experience. Like other interviewees who had similar, positive experiences, he became involved in the life of the community at Site 3; he began to meet other residents at the facility, and he also maintained a number of his community ties. With regard to getting to know other residents in the facility, Walter said, "I did hit it lucky because two people in here were from down at the senior center. And one of them still lives here but she's in the hospital. As soon as I moved in they said, "Oh, we're glad you're here!" And then we eat at the same table all the time." Walter also described himself as a person who "never did have trouble getting in with people." He said that one of the things that helped him during the transition period was, "…just the fact that we kept talking and anything...like we talked sports or anything that way and just mixed in with the crowd that way." When I asked if getting involved in the activities offered by the facility was helpful during the transition process, he said, "Yeah, yeah, yeah…I tried to get as involved as possible." Walter met a woman with whom he plays scrabble almost everyday. Additionally, he shared that he "just got elected resident council president" at Site 3. Finally, Walter became involved in the spiritual life of the

assisted living community and when asked if his faith was a resource to him he said, "Yeah, it has for me because it's great to be able to go to [religious service] every day. I don't miss it unless there's a football game on!"

Like other participants who seemed to have a positive aging experience and transition to assisted living, Walter continued to maintain his established community ties. When possible, he still attended political party meetings. Also, he kept in touch with his church community and regularly participated in the religious men's group of which he was a member. "The guys [in the men's group] are doing really good. They come and get me and take me to all of the meetings." To accommodate Walter, the group even offered to hold one of their monthly meetings at Site 3.

With the many positive developments that Walter shared, I wondered if he had any regrets about relocating to Site 3 or if he noticed any disadvantages. He responded, "No, I can't say that I regret it…knowing what the condition was and I knew it wasn't going to get any better with my handicap and all. I knew it wasn't going to get any better."

The main themes that surfaced in Walter's interview touched on the factors that precipitated the transition—the transition was related to health challenges that could not be overcome without the help of another person(s). Walter also talked about loneliness as well as a loss of independence, as symbolized in giving up his car. The more striking themes, however, were related to positive developments in Walter's approach to the transition, including maintaining existing relationships, creating new relationships, taking on a leadership role at Site 3, staying focused on his own needs, and preserving community connections. These themes are summarized in Table 9.

Table 9

Summary of Intra-Case Analysis: Themes from Interview 5

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging / Supportive Factors**
	Ill health	Loss of Independence/freedom	Surrender to the decision to transition	Focus on Self
	Desire not to burden family	Sense of loneliness	Decision accommodates children	Forming new relationships (with staff and residents)
	Self-initiated decision to move	Physical decline		Maintaining existing relationships
	Desire for dependable care			Community involvement inside AL
				Community involvement outside of AL
				Spirituality/faith as a support
				Involvement in the investigation of facilities and decision making

Individual Interview 6: Rose

Rose is a soft spoken woman of 87 years, and she struck me as a quiet, practical woman who valued simplicity over frills and who saw sensibleness as a virtue. She was the only resident in this inquiry whose spouse was still alive. Her husband, however, did not live with her at Site 1 because he suffered from Alzheimer's disease and had to be cared for at a nursing home about 10 miles from the assisted living facility where Rose resides. Rose's only son picks her up at least twice a week, and they go to visit her husband, to whom she has been married for 66 years. Rose has resided at Site 1 for the past 7 months in a small, single room with a private bathroom. As we sat together in her simple, sparsely furnished room, she shared with me how she had relocated to Site 1.

Like most other interviewees, Rose encountered a number of health challenges in the recent past that required her to be hospitalized before she eventually relocated to Site 1. “One night I couldn’t get my breath, and they called the emergency, and I went to the hospital, and after that they found out I had congestive heart failure. But, to start with, I had two operations on my leg.” Rose had had a vein graft on each of her legs, and she had nursing help at home during the time she was recovering from her leg surgeries. The health challenges that Rose faced limited her ability to take care of her husband as well as her ability to complete the other tasks associated with the upkeep of her home, such as housekeeping and grocery shopping. Additionally, Rose mentioned that the financial burden of keeping her home and changes in their neighborhood played a part in her relocation. “It was getting so expensive living in a house. You can’t hardly live in a house anymore…” she said, and then mentioned, “…there started to be robberies and stuff in the neighborhood.” Rose said that given these challenges, her only son and daughter-in-law encouraged her to leave the area. Even before her health problems, “…they were definitely thinking I should move….” I wondered how much Rose herself had contemplated relocation, and she said, “Oh, I think you think you can go on, you know, but then when you get serious about it, you start thinking different.” Rose talked about a number of social and biological factors, therefore, that played a part in the eventual transition out of her home and into assisted living; however, the activating factor was her own health crisis. For clarification, I asked her if the congestive heart failure was what “got things in motion” and she responded affirmatively, “Mmm hmm, oh yeah.”

With her hospitalization, Rose said she did not have a chance to look at any assisted living facilities before she moved. When I asked if she was part of the decision

making process about transitioning to assisted living, she shook her head no. “My son and daughter-in-law looked at this place,” she said. Moreover, according to her pastor, “this was the nicest place he had been.” Several influential people in her life had been a key part in the transition process. Rose appeared to have accepted their decision, though, that she would move to Site 1. “I trust them that they know what they’re doing.”

I talked with Rose about the loss experiences she encountered that were related to the relocation and specifically asked her if she had left anything behind in the move that she identified as valuable. “Oh yeah! I left behind just about everything. All I have is that desk and those lamps and that chair you are sitting in,” she said to me. She did not know what had become of most of the other items in her home, except that her son was “taking care of it”. I wondered what impact the loss of personal items from her home had on Rose and asked if she ever thought about the things she left behind. Emphatically she declared, “Oh yeah! But, you know you can only put so much in this room. This is one of their smaller rooms.” Rose mentioned, “It’s been hard giving up all my things,” and then with a sensible wistfulness, “…but sometimes you’ve got to change your way of living.”

Not only was it difficult leaving behind personal possessions that were meaningful, but leaving her home was, in itself, a loss. “We lived in the same house for 48 years,” Rose said. “My husband built that house.” Curious about the psychological effect leaving her home for assisted living had on her, Rose responded to my inquiry. “Well…you know…it was disheartening, but what you gonna do…?” Rose said she never had the opportunity to return to her home after she went into the hospital for her heart problems and also never had been back to take any of her items. Her son and daughter-in-law “don’t want me to go back because they probably think I’ll be depressed

because they've gotten rid of all my stuff," Rose contributed. The biggest loss or most difficult part of the transition, however, was "being away from my husband, especially since we were married for 66 years. That's a very long time." "He couldn't be here," Rose said, "because he needed more help than they could give."

Like some other participants, Rose espoused a sensible attitude towards the transition. "You have to do the best you can," she stated, and "take it one day at a time." "You'd rather stay home if you possibly could, but you know when you think about, you've got to be reasonable." It seems that this attitude of being reasonable was one of the coping mechanisms that Rose employed to help her adjust. She viewed the transition as one of the changes of life—assisted living did not necessarily make her life experience better, but it was a change to be endured. "It's a change. You change all your life. You're born and then you're a teenager and you keep going up…" When I asked Rose if the transition was another one of the changes of life she replied, "Yes. It has been for the past seven months…I used to be pretty active…." Accepting the change as part of life, though, had not protected Rose from being emotionally affected. "Sometimes it's depressing living here…," she commented.

During the course of our conversation, Rose talked about a number of other themes that also emerged for other participants in this inquiry. One aspect of the transition she experienced was related to changes in her identified roles and activities. "I used to do a lot of washing, ironing, and all that stuff—household stuff. And then, all of a sudden nothing!" Another theme that surfaced was related to wanting to maintain her lifestyle and independence as much as possible; it was not able to be preserved as it had been at home. For instance, in reference to the schedule she was required to maintain at

Site 1, Rose said, “You’re sort on like a routine. At home, I did what I wanted to when I wanted to. Here, you have to get up at 6 a.m. to get to breakfast. It’s sort of routine.” Finally, echoing the thoughts of other interviewees who did not want to be a burden to their children in their old age, she stated firmly, “I don’t want to live with anybody. I think you’re better off if you stay by yourself. My mother in law lived with us for 26 years…” She said of her son and daughter-in-law, “I don’t think they want anybody moving in with them….”

Rose also identified a number of supportive factors that helped her through the transition. Of her relationship with her son, she said the relocation to Site 1 brought her closer to where he and his wife lived, and so as she stated, “I see him more, oh a lot more…” Rose appeared to have a positive relationship with her son. “He does everything for me,” she stated. “He’s a real good kid…I never had any trouble with him. When I first came here he took me to the doctors and everything because I didn’t know my way around here. When I first moved here, he took me everywhere….” Rose also became involved in a few of the activities, including bingo and cards and had gotten to know the residents with whom she dined. “I think you have to make your own friends.”

The themes that emerged in Rose’s experience reflected a number of those that emerged throughout the inquiry. Health challenges were the activating reason for her to relocate to assisted living. Rose experienced a sense of loss related to leaving her home, her personal possessions, and a lifestyle that she determined through her own personal routine. A primary coping mechanism that Rose used to aid in the adjustment was an attitude of practical acceptance. These and other pertinent units of meaning are summarized in Table 10.

Table 10

Summary of Intra-Case Analysis: Themes from Interview 6

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging / Supportive Factors**
	Ill health	Loss of Independence/freedom	Surrender to the decision to transition	Focus on Self
	Desire not to burden family	Sense of loneliness	Decision accommodates children	Forming new relationships
		Loss of valuable/meaningful items in the move	Lack of involvement in decision making process	Maintaining existing relationships
		Loss of self-determined lifestyle		Community involvement inside AL
		Role/ identity changes		Community involvement outside of AL
				Spirituality/faith as a support

Individual Interview 7: Millie

Millie is an 87 year old resident of Site 1 and one of the women I met on my second visit to this site. She was chatting with another interviewee, Maureen, when I arrived at the facility and happily agreed to participate in the study. Unlike most other participants, Millie described herself as beginning to be aware that she is forgetful: "I'm losing my brain." Given Millie's own self-description and my assessment, I carefully explained the purpose of the study, the protections of confidentiality that were in place, the right to withdraw from the study, and my desire to tape the interview. Millie consented to participate, and at the end of the interview, I reiterated how I planned to use the results of our interview and that her identity would be protected. Despite her forgetfulness, Millie still was aware of details of the transition experience that had occurred 4 months ago and the impact it had on her. I asked Millie at a certain point in our interview if the effects of transition were decreased or eased by her mild forgetfulness, and she stated emphatically, "I really don't think that is true. I remember

everything about it." In the interview, she corroborated the experiences of other participants who felt lonely, isolated, and not fully happy as a result of the transition.

Originally from New Jersey, Millie and her husband had moved to Ohio early in their marriage and had settled in the Columbus area, where they raised their two sons, one of whom lives in England and the other of whom lives very close to Site 1. Her husband died several years ago, and prior to moving to Site 1, Millie had lived in a home that she had rented for a number of years. She used to "have a girl who came in and cleaned and did other stuff" twice a week while she lived at home. Slowly, her lifestyle become less independently oriented. One of the most difficult losses was giving up driving. "That was the hardest thing…I decided to stop driving because I didn't want to hurt anyone or myself," Millie said. When I asked Millie how she finally had come to Site 1, she said, "…the children decided…no…[Son] decided, 'You gotta come here, mom.'" Her son who lived close to Site 1 appeared to have taken a very active part in talking to her about assisted living as the best long-term-care option for her. Millie stated that it was "absolutely" hard to leave her home and household possessions behind, but "there was no question…it was, 'You gotta do this mom.'" Later she said, "I wasn't happy about it at all, but there was no point in arguing about it. This was something I had to do." I responded to Millie that it seemed like her children really helped her to make the decision to come to assisted living. She laughed and then mused, "I think they made the decision, and then I had to come." Two other participants in this inquiry described similar experiences of feeling as if they did not have a voice in the decision making process to relocate to assisted living.

When Millie made the actual transition into assisted living she described it as "rough." I wondered what rough meant for Millie, and she hinted at a theme that had emerged for other interviewees related to loneliness. Describing the rough part she said, "I suppose it was about meeting people. Catching up on what was going on here..." However, the most difficult aspect of the transition was "knowing that I didn't want to [move]". Toward the end of the interview, Millie shared, "Sometimes I think I'm too well to be here. There's nothing really wrong with me. I don't know why they put me here."

During the course of the interview, I asked Millie about the types of things that helped her "get used" to being at Site 1. At first, it was difficult for Millie to identify factors that eased her adjustment. "I'm not altogether sure I'm used to it," she reflected. To emphasize her point, she said, "I can't tell you truly that I'm happy here, but on the other hand, I've got to adjust. This is what the kids want me to do." Like other interviewees, Millie took a sensible approach to the transition, which may have acted as a buffer against some of her discontented moments. "They [the children] had to do what I wanted them to do for a long time, so it's my turn now." Millie recognized that she could have gotten angry about her children's decision on her behalf and could have told them, "I won't do it." However, she decided to trust them. "They're smart. They know what's going on." Assuming a sensible approach also helped her deal with relinquishing her personal possessions, for which her son and his wife took responsibility. Millie stated, "I could have been rotten and said, '[Daughter-in-law] why did you have to take *that*...?' But, it's over and done with." Being practical and reasonable was one protective factor that aided Millie in the transition; another factor was tied closely to how she was welcomed by the staff of Site 1 when she first arrived. "You know, the people working

here, that's who I'm talking about…everyone knew my name." "And that was important?," I asked. "Sure," Millie said. "Don't you think everyone wants their name to be known?" Like other participants, Millie witnessed to the importance of a caring staff in making a good transition.

Finally, Millie briefly touched on another theme to emerge for some participants related to myths about aging and older adults. In recounting a story about a family get-together, Millie mentioned that she sat alone for quite a while at this gathering. She said, "They all think I'm fragile and you mustn't touch." And then to me Millie said, "Don't forget that!" as if giving me some advice about how I may be treated in my older years.

The identified themes in the interview with Millie are summarized in Table 11. Some of the more noticeable themes are difficulty making social contact, feeling left out of the decision making process, sense of dissatisfaction with the transition, importance of staff disposition in easing the transition, and cultural stereotypes about older adults.

Table 11

Summary of Intra-Case Analysis: Themes from Interview 7

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging / Supportive Factors**
	Ill health	Dissatisfaction and unhappiness with the transition	Decision accommodates children	Focus on Self
	Desire not to burden family	Loneliness	Lack of involvement in decision making process	Forming new relationships (with staff)
		Loss feelings related to home and possessions	Necessary acclimation	Maintaining existing relationships
			Myths and stereotypes about aging (fragility)	Spirituality/faith as a support
				Staff attentiveness as a support

Individual Interview 8: Julie

I first met Julie at a resident council meeting at Site 3 during which I had an opportunity to explain the purpose of this inquiry to the residents. She willingly agreed to participate and told me, "I love to talk. This will be fun!" Indeed, when I returned to Site 3 about a week and a half later and knocked on Julie's door, she smiled at me, invited me into her tastefully-decorated and cozy room, and proceeded with obvious joy to tell me about herself, her family, and her transition to assisted living for the nearly two hours we spent together. My overall impression of Julie was that she had decided to age in as positive a way as possible; she took advantage of every opportunity to find happiness, sense of purpose, and enjoyment in her life, and if such opportunities were not at first obvious, *she* sought them out. After having lived a year and a half at Site 3, she seemed to be content and comfortably settled into her life in assisted living. A cliché she used in the interview that characterized her approach to life was, "If you laugh, the world laughs with you!"

At 89 years old, Julie, a widow of over 40 years, appears much younger than her age. When I commented on her youthful looks, she laughingly said she is aware of her 89 years, "only when I look in the mirror!" Other features of Julie's surroundings also were interesting given her age. I noticed that she had a new, flat screen computer monitor, computer tower, and printer sitting on her desk. Moreover, there was neither a walker, nor a wheelchair anywhere in sight. Given the lack of physical aids and the presence of the computer, which suggested she was mentally alert, I was curious about what precipitated her transition to Site 3.

Despite the absence of walker, cane, or wheelchair in her apartment, Julie's decision to relocate to assisted living, like almost all other participants in this study, had involved a physical health setback. "I was calmly sitting in the chair reading one day and the telephone rang, and I got up in a hurry to answer the phone…and I pulled the muscle in my knee, and I was just debilitated. I couldn't drive. I couldn't get out to go to the grocery. [Daughter] was living in [City], and she would have to come down to take me every place." During the recovery process, Julie recounted, she began to think about her health challenge and her future care. "What if this were permanent?" Julie wondered. "Suppose I had a stroke or something? This is unfair to [Daughter], and the other kids…[Daughter's] husband said, 'You come live with us if you're going to live alone.' And…but I didn't want to do that."

When I mentioned to Julie that a number of other older adults in this study echoed her thoughts about not wanting to live with or burden their children, she readily agreed. "Yes! That's what I was thinking." Curious about the desire not to burden her children with her care, I asked Julie to tell me more about that desire. "I guess I just felt…by this time I had been on my own so much, being independent about making decisions…but basically I was so independent that I guess I didn't want to go and live with my children because I wouldn't be independent. Whatever they were doing would be the program for the day." "Moving in with them would restrict you somehow?," I asked. Julie laughed and replied, "Yeah…just basically, I'm bossy!…(laugh)… For so long I had to make the decisions for the children. When [Husband] died the children were still little kids and all along the line I kept [making the decisions]…I still wanted to be independent." Clearly, the theme of independence that arose for other participants in this inquiry was central to

Julie's experience, as well. Interestingly, though, Julie viewed moving to Site 3 as a way to maintain her independence rather than a hindrance to her freedom.

We spoke about how Julie finally had come to the decision to relocate, the role that other people in her life played in her decision making process, and the degree to which she experienced the transition to assisted living as an autonomous choice. She shared that she had visited Site 3 before she sold her home and knew what type of services it offered. Originally, she wanted to move to the independent, apartment-style living quarters of Site 3, but it sustained damages in a natural disaster that occurred about the time she wanted to move. She knew she did not want to wait for the rebuild. "I'm ready to go now," she decided, and, fairly certain of what she wanted to do, Julie said, "I got in touch with all the kids and said, 'You know, I'm thinking about going into [Site 3].' There was kind of a sigh of relief among them. I guess [Son] put it best: 'I'm so glad to hear that, because every time I call home and you don't answer I'm sure that you fell down the basement stairs." The decision to move primarily was an autonomous one in which Julie had not consulted her children. "I just always thought…what am I going to do? Because I knew there was going to be a time when I can't….[take care of myself]." I had the overall impression that Julie had made not only an autonomous decision, but an informed choice that was motivated by a sense of readiness. Sharing these thoughts with her, Julie responded, "Right! Right!... I keep telling my kids this. Don't wait until it's time to move that you decide what you're going to do. Be thinking ahead about: How would I like to live? I want a place where I'm safe… it had to be someplace where I was completely taken care of as you are here. But at the same time you are always free to go out and there's no restriction on how often you go out."

By Julie's admission, she was intimately involved in the process of transitioning to Site 3, and she even had had an opportunity to visit the facility prior to relocating. Given her level of involvement, I wondered if anything about Site 3 had surprised her after she moved in and whether or not she had any difficulties in the transition despite her preparations for the move. Without much hesitation, Julie responded, "This sounds crazy, but I never encountered any difficulty in making the transition. See, I made the decision. The kids didn't come and say, 'We think you ought to be moving into something…' I made the decision. I'm queen of the mountain here!" Julie later hinted at the importance of having made an autonomous decision to transition. "When I make a decision, like move here, it's what I want to do. If anybody had told me, 'No you don't want to do that. You wait 5 years to do that,' I would have been angry about it because I want to make the decisions. It's egotism," she said. Finally, because she had already been living at Site 3 for a year and a half, I inquired of Julie how she had experienced her first few days at the facility. In confirmation of what she stated about not encountering difficulties, she responded, "I felt at home from the minute I moved in. The administrators were just so gracious and the residents, too, I mean four or five of them coming up and saying, 'Welcome.' That just meant a whole lot. You felt like you were sitting out on the back forty…(laugh)."

Julie seemed to identify more advantages than disadvantages with her relocation to assisted living. In a number of ways, her transition experience reflected the experiences of other residents who appear to have taken a positive approach to the process of aging; Julie fully engaged in finding ways to satisfy her own needs, she maintained and fostered her current relationships and volunteered her services to the

community of residents at Site 3. First, in meeting her own needs, Julie maintained her sense of privacy, which she valued, even while living in a community of other adults. "I was not a person who ever had a bosom pal…I kind of played the field! I enjoyed just getting acquainted with the different people and so on. But, ah…I don't have a really close friend…." Meeting other residents and not creating a very intimate relationship seemed to suit Julie, who said, "I want my privacy. When I come home, I want this to be my space." She perceived that, "…around here a lot of people think I'm snooty because I don't go down and play bingo. I think bingo is a waste of time!" However, Julie made a conscious choice in how to meet her own needs socially and also protect her sense of privacy. "I know I act very independent. I do what I want to do around here."

Julie also met her own needs by engaging in activities that were personally enjoyable and by seeking out new hobbies. Trained as a librarian, Julie long had worked in school libraries, and reading was one of her passions. She shared, "I do a lot of work down in the library. When I first arrived they ask what your special interests are, and I put down library, so I'm one of the co-librarians now! And I enjoy that. I go down in the morning and straighten up the place and in the evening…" Not only does she straighten up the library, but Julie also helped to organize and shelve the more-than-2,000 books in the library, and she catalogued the inventory so the residents and administrators would know what books they housed. Besides co-coordinating the library, Julie also professed, "I'm very active in writing." Finally, she recently had taken up watercolor painting. "I used to oil paint," she said, "but they would smell too much to do in my room, so I've decided to try watercolor instead." Engaging in these activities all seemed to act as protective factors against negative effects of the transition process. Having the

opportunity to work in the library, for example, helped prevent Julie from experiencing a sense of loneliness or isolation, "because I got my room settled here and the next thing I'm down in the library…So immediately, I had a full time job down there." When I specifically asked Julie if her hobbies were part of the reason why it was so easy for her to make the adjustment, she responded, "Yeah, I think so…yeah." To emphasize her point, Julie said, "Anybody going into a home…residence like this, I would say, be sure you got a couple hobbies that you can carry out." To summarize her belief that actively seeking out new interests was important in older adulthood, Julie said:

> Develop as many different interests as you can. You don't necessarily have to become an expert in anything but take the taste of something because when you retire there are certain things you can't do anymore. I used to like to hike through the woods, but I don't hike very well now. Then when you retire you've got all these things to draw on.

Finally, Julie identified her faith as a resource in the transition process that enhanced her resilience to the transition; this also was a factor for other participants in this inquiry. Of her faith, she said: "Oh, believe me that's what carries you through. My husband said, 'You don't worry about things. You turn them over to the Lord.' And that took me the longest time. You know I'm bossy! I always want to be in command. When I finally realized…there's help from up above." Before and during the relocation to Site 3, Julie stated that, "I always prayed, 'Dear Lord, help me to know what to do.'"

Overall, Julie identified more advantages to assisted living than disadvantages and exhibited numerous signs of positive aging. Like other residents, however, she briefly mentioned that, "I won't say that I don't miss things…I could hop in the car and do what

I want…but now I can't do that. I miss that independence of coming and going. But here, if you watch your step you can arrange your life." Although the transition primarily was a way for Julie to retain her sense of autonomy, she also recognized a degree of loss inherent in letting go of her former way of life.

Another possible disadvantage or psychosocial risk that Julie subtly hinted at was becoming a loner in the facility. In many ways, I got the impression that Julie valued her privacy and was content to live a semi-private life. On the other hand, she stated, "I don't know whether it's a good idea to make a real, real close friend…I want friends, but here, I can't tell you how many people have died or gone into nursing homes since I've been here. And, if you let yourself get too attached to people like that, then it's a wrench when they are taken away." Julie's awareness about the closeness of death and degeneration also had resonated with another participant in this inquiry, who consciously stopped interacting with other residents in her facility because the death of her acquaintances became too much to bear. When I shared with Julie the reaction the other participant had to the deaths of her friends, she acknowledged, "When you're in a place like this, you are very conscious of the ravages of old age. Let's put it that way."

In spite of the disadvantages that Julie hinted at as having emerged in her transition to Site 3, my general impression was that she actively engaged her life, that she was contented with her decision to transition to assisted living, and that elements in her environment, such as supportive kids ("I've got four of the most loyal children," she stated) and welcoming residents, as well as her own attitude to the transition, made it an opportunity for continued development for Julie. She put it best: "I know that I sound

self-satisfied…but I am!" Table 12 summarizes some of the main themes in Julie's transition experience.

Table 12

Summary of Intra-Case Analysis: Themes from Interview 8

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging / Supportive Factors**	**Other**
	Ill health	Loss of independence		Focus on Self	Increased awareness of death / ravages of old age
	Self-initiated decision	Lack of social relationships within the facility		Forming new relationships (with staff)	
				Maintaining existing relationships	
				Spirituality/faith as a support	
				Maintaining roles	
				Engaging in new hobbies	
				Community involvement within the facility	

Individual Interview 9: Theresa

Theresa is an 85 year old woman who has resided at Site 3 for 10 months; prior to her transition, she lived independently in a senior apartment. I met Theresa at a resident council meeting, where she agreed to participate in an individual interview with me. When I returned to the site about a week and a half after first meeting Theresa, I knocked on the room of her door, and she welcomingly invited me in to chat with her. I experienced Theresa as a very pleasant woman who was contented with her decision to relocate to assisted living at Site 3 and who identified more advantages than disadvantages with her transition.

Like most residents in this inquiry, Theresa experienced a number of health challenges that prompted her to move to Site 3. For 12 years, Theresa, who never married, lived in a condominium on her own. Suffering from several forms of arthritis, she reached a point at which she experienced difficulty navigating stairs in her condominium and decided to move to one floor plan in a senior apartment building. After living for five years in the apartment, she noticed that she "was not getting around too well anymore" and pointed out that her "knee is in terrible shape," which made walking difficult. Moreover, Theresa said, "I couldn't cook for myself in the kitchen…so I wasn't eating properly. I wasn't getting dressed because it hurt too much. And I wasn't getting out of my apartment."

The health challenges Theresa experienced not only limited her ability to function in her daily routine, but they also contributed to Theresa's living in a state of fear. Ultimately, Theresa's desire to be in a safer environment with greater support systems than what she had in her apartment also played a role in her decision to transition to assisted living. "I was getting so that I was nervous in my apartment." Because of her fear of falling, in particular, Theresa thought it was time to consider assisted living. She contacted the administrator at Site 3 and talked to her about her situation.

> I told her [the administrator] how limited my life was becoming, and I didn't like that…and being alone all the time and not feeling…not taking advantage of things because I hurt all the time. And, I was getting scared. That was one of the big things. I used to take a shower every morning. I was too frightened to get into that shower by myself. And once you are afraid, it consumes you! I guess I didn't

know this because I never felt this way before, but I was so afraid that I would fall that I was afraid, afraid, afraid!

Theresa was aware of the limitations and barriers she faced by living alone and seemed to have been considering relocation to assisted living before she actually moved. When I asked her how she made the decision and who was part of the decision-making process, she responded by talking not only about the decision to move to Site 3, but also about prior decisions she faced. "I made all my decisions. I made my decision to stop driving. I made my decision to give up…to sell my condo. I make all my decisions!" When Theresa called the administration at Site 3, she recalled that she told the director, "I think I belong in assisted living." Curious about the effect that exercising her autonomy had on her adjustment to assisted living, I asked Theresa, "Do you think that [making your own decision] had an effect on how well you were able to adjust to the new environment?" Replying affirmatively, Theresa said, "Yes. Yes…I think if somebody told me I had to move here, I wouldn't have…I maybe eventually would have adjusted, but I would not have adjusted as well."

Like a number of other participants in this inquiry, Theresa characterized her relocation to assisted living as part of a self-initiated decision, and her autonomous choice was influential in her ability to experience a sense of contentment living at Site 3. As she stated, "I love it here" and "we're lucky, lucky, lucky to be living in a place such as this." Given her appreciation for her situation at Site 3, I asked Theresa about some of the advantages that she experienced as a resident of Site 3. This biggest advantage that Theresa identified was related to a sense of safety and relief about not living on her own and being afraid. After the transition, she stated, "the fear really was gone in a week!...As

far as I was concerned, that was the biggest thing—getting rid of the fear." She also mentioned that it was important that "other things" were also taken care of, such as having help getting dressed and getting out of her room.

Related to the personal advantages Theresa experienced as a result of her transition to Site 3, there were a number of environmental supportive factors that were both advantages and aids in her adjustment. A number of other participants in this inquiry talked about the influential role of staff attentiveness in the adjustment process, and in Theresa's case, this was strikingly evident. The presence of caring staff, first, helped to decrease a sense of loneliness. Theresa stated that she "was not aware of any loneliness" when she moved in, partly because, "there were people around all the time. The aides dropped in on new people to introduce themselves, and that was very nice, I thought." Theresa specifically mentioned one aide that she appreciated. "During the first hour that this aide is on, she goes around to all her rooms and tells them to call her if they need anything. She really wants to keep a good thing going with her clients." Additionally, the attentiveness of the aides and the nurses at the facility helped to prevent Theresa from re-experiencing the nervousness she had when she was in her apartment. She shared a story with me about a time when she faced a health challenge at Site 3 and concluded by saying, "I'm telling you that as a way of how they took care of me and immediately. And, I wasn't afraid, and I wasn't nervous. I had people who knew what they were doing, and they were doing it. And I was in good hands, and if they thought for one minute that I needed more, they would be on that phone to the hospital." Another staff member that Theresa talked about was the activity director, who Theresa saw as very kind and approachable. "I have never heard a tone in her voice, no matter to whom she is speaking

that she…I have never heard a tone in her voice that would indicate that she was annoyed with what you were saying or requesting….” Finally, Theresa talked about the support she received from her niece who worked at Site 3. Theresa recalled that during the actual move, “my niece and her husband made it very easy for me because they were family moving me in.” Following her relocation, Theresa’s niece continued to offer her support. “She sat me down and told me anything I needed, I was to call her. She had five children and had a lot of things to do in order to make do, but she could add me to her list! So she…I don’t want to call her for a whim or something, so what I use [my niece] for is medications. I have her get my medications.” Moreover, Theresa said that her niece and family occasionally take her out to dinner or to their house for a visit.

Theresa clearly was satisfied by the response of the staff and the aides at the facility who were responsible for her daily care. She also made a powerful observation about the director and the management approach at Site 3 that obviously were positive factors in the transition process. She shared this observation: “The administrator comes to breakfast every morning in the dining room at 7:30, and I don’t know how long she stays—at least a half an hour—pouring coffee. She doesn’t have to do that. There are plenty of servers, but she makes it her business to go to every single table and say, “Good morning, [Name of resident]. She calls us all by name.” I asked Theresa, “What does that mean to you?” After a thoughtful pause, Theresa said:

> It means to me that she knows who I am, and I certainly know who she is. It means a really family—that she cares enough to come to the dining room every morning earlier than she would have to because she’s the administrator and she wouldn’t have to be there until 8 a.m. if she didn’t want. It means a great deal to

me. I told all my relatives. I am telling you because it means a real family feeling that she cares.

Struck by what Theresa had shared, I commented that she must have a sense that *she* is important—more than just a check in the bank. "Exactly! Exactly! In many places all you are is the check that goes to the bank. I know quite a few people who live in facilities by people they don't even know who owns it." "And here," I probed, "you have a feeling that you're connected to the top management?" "That's right!," Theresa declared, "and the money stays here to take care of us. It doesn't go to a bunch of doctors in Arizona…"

With the many positive components of Theresa's transition and supportive elements in the environment at Site 3, I wondered if Theresa had experienced any difficulties related to relocating. After inquiring of Theresa about difficulties, she initially said, "I can't think of any." However, she briefly mentioned two aspects of the transition that were small barriers. First, she mentioned, "You know, the food here isn't the greatest…when you're cooking for over 40 people, it's institutional food." Second, when I asked Theresa whether or not it was hard to leave behind some of her personal belongings, she, like a few other residents responded, "Yes…it was. At first, I had a little difficulty. For instance, I had a couch I really liked and I really wanted it with me, but I couldn't bring it because it would be too cluttered in here."

Unlike most other residents, Theresa did not experience a sense of lost independence or autonomy as a barrier to the transition. In fact, when I wondered about her decision-making power at Site 3, she stated, "Living here, nobody tells me what to do at all. Nobody. [Activity director] frequently stops by if there is a program she thinks I might be interested in. I go to most of the programs…I don't have to ask anybody. So, I

choose on my own to go. I go for my own enjoyment, and I feel I have a little obligation to go to programs she has put together. She has good programs."

In trying to sum up her transition experience to Site 3, I said to Theresa, "It sounds like you have made a pretty good transition here." She agreed: "I don't think it could have been any better. I don't know how it could be, because I'm very content. I'm very content here. I said to somebody, 'If I complain about anything, I ought to get a good kick in the pants! Because I have no need to complain.'"

Table 13 provides a summary of the major themes that emerged in Theresa's lived experience of relocating to assisted living. Precipitating factors including health challenges, fear, and a self initiated decision emerged. Two barriers, including institutional food and loss of personal items in the relocation surfaced in Theresa's experience. The most powerful themes to emerge, however, were related to supportive factors that aided in the transition process.

Table 13

Summary of Intra-Case Analysis: Themes from Interview 9

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Aging, Subjugation**	**Evidence of Positive Aging / Supportive Factors**	**Other**
	Ill health	Loss of valuable/ meaningful items in the move		Focus on Self	Dissatisfaction with food
	Self-initiated decision	Physical health decline		Forming new relationships (with staff)	
	Fear of living alone/falling			Maintaining existing relationships	
				Staff attentiveness as a support	
				Personable/ caring attitude from facility management	
				Community involvement within the facility	
				Involvement in the investigation of facilities and decision making	
				Family involvement as a support	

Individual Interview 10: Naomi

Naomi, who is 88 years old, has lived at Site 4 for just over 2 years. She relocated from a townhouse in the suburbs of a large, out-of-state, Midwest city to an independent senior apartment where she lived for about 2 months before transitioning into assisted living. Although her sister and niece lived very close to her home, neither of Naomi's children resided in the state where her house was located and her husband had been dead for a number of years. Her choice of facility, therefore, largely was influenced by its proximity to one of her children (in this case, her son). Extremely alert, reflective, and candid about her transition experience, Naomi provided an enlightening description of late-life relocation to assisted living. During our hour and a half conversation, Naomi

talked about many themes that resonated for other participants in this inquiry, especially themes related to precipitating factors to relocation and supportive factors that aided her throughout the transition process; she also offered some unique perspectives on what it means to be a resident in an institutional setting and about potential barriers to a positive adjustment.

Echoing the stories of almost all of the participants in this investigation, Naomi told me that her thoughts about moving to a facility emerged after she had encountered numerous health challenges in the four years prior to her relocation. "For the last four years before I moved, it seemed that something went wrong. I had to have bypass surgery, and I had to have colon surgery, and I had…fallen and broke a hip." Following these health problems, Naomi's son told her, "I'm back here every year…because something's happened. Wouldn't it be easier if you came to live...closer to me?" Her son's invitation prompted Naomi to consider more seriously the idea of leaving her home, though in the end, she said, "My decision to move here was prompted by my son, but also I could see the sense to it. I would have to go someplace. I feel that I definitely made up my mind, and my son made me welcomed to come here, because by my being here it was going to affect them...."

In addition to the rise of health problems, which were creating barriers to her ability to care independently for herself, and her son's suggestion that she move closer to him, Naomi also talked about other factors that influenced her decision to relocate. For instance, she evaluated her options for health care services and did not find any that were appealing or that could fit her needs. One of the options she investigated was in-home health care, but she had doubts she would be able to find someone to provide services

when she needed help, and moreover, some of Naomi's friends who had in-home services had encountered difficulties with the care-givers. Of one friend's situation she said, "the aide started wearing all of her jewelry—all of her rings and bracelets and necklaces…" and of another friend's care-giver, she stated, "my friend stopped being able to watch her shows because her care-giver always turned the TV to the station she wanted to watch."

Finally, a central reason that Naomi decided to move to assisted living was to avoid becoming a burden to her family. This precipitating factor emerged not just for Naomi, but also for a number of other interviewees in the inquiry. Before she actually moved, Naomi already had relied on friends and family for assistance, and she clearly was not comfortable with the "burden" she was becoming to them.

> It was difficult to find somebody to pay to drive me back and forth to the doctor. My friends were doing it, and I just couldn't let them do it anymore, and it was a matter of pride. I thought: Enough is enough. So I think that is what, more than anything else, that's what cinched it—that I should get a facility that could take care of me."

Naomi believed that in the face of her health problems and her age, she would have depended on her sister and niece for help had she stayed in her home, and she did not want to continually impose on them. To confirm what she was communicating, I asked Naomi, "Was there a part of you that did not want to be a burden to them?" To this question, Naomi emphatically replied, "Definitely. I did not want to be a burden to them."

Because the idea of not being a burden had surfaced before in other interviews, I asked Naomi to talk a little more about it, and specifically, I asked her why it was so

important not to be a burden. Naomi answered my question by talking about the issue of independence—her own and that of others. She stated, "Well, it's your independence. You want your independence." Even in a facility where people are paid to help with activities of daily living, Naomi said that it was important to her to "make it easier for them" by lifting herself and getting out of bed on her own if at all possible. When I asked her if, by doing such, things she was able to maintain some sense of her own independence, Naomi said, "A sense of independence…yeah, that's correct. Yeah." The other side of the issue of independence was related to Naomi's belief that she should not be a hindrance to *others'* freedom. "My sister, as I say, is seven years younger than I and has had a heart problem all along. She's getting older and I'm getting older. You're almost better dealing with strangers. She would have done anything for me—it wasn't that. I just couldn't put that on her. And, I think most people…would not want to be a burden to anyone." Reflecting on her sharing, I vocalized to Naomi that she seems to value others' sense of independence and wants to avoid diminishing it. Very affirmatively, she said, "Yes, that's right. That's exactly right…" and then stated, "Let's say I was calling you everyday—everyday. You have a life! You can't be running at my beck and call." Finally, at the end of our interview, the theme of not being a burden resurfaced, and I asked Naomi if she had ever considered living with her children now that she needed assistance. Without hesitation, she declared, "Oh, no. No, no, no. Never." While growing up, Naomi had two relatives who had lived with her family and then, during her marriage, her mother-in-law also lived with her and her husband for a short while. Although she testified that "it was fine for us," she also said, "but I would never do

it if possible. Even with my son and daughter, as close as we are, I figure this is their life…I would never do it. It's their life, and you're bound to get involved in it…."

While Naomi was telling me about her health problems and how she finally decided to move to assisted living, she said she sold her home quickly and, as an afterthought, mentioned, "Sometimes, I wonder if it wasn't too quick…" The hesitation that was evident in her description of the experience suggested that, even after living for two years at Site 4, she still felt a sense of loss related to leaving her home; the transition experience was ongoing—not necessarily resolved. "I'm still dealing with it [the transition]!" she exclaimed. With this entrée, we began to talk about the various losses that Naomi sustained as a result of moving to Site 4. Similar to some other participants, Naomi talked about the loss of her personal possessions. "When I moved out of the independent apartment to here, I don't know where a whole lot of things are! Little things…but I'd just like to know where they went." More significant to Naomi, however, was the separation from her home itself, her community, and her social connections. She described some of the most striking things about leaving her home this way:

> Well, it was leaving my home, which was a big item, but I was leaving the state. I was born in [State], and I had a sister that was four doors away, and I had a whole complex of friends that were there…that was equally as traumatic—leaving all those people. The night before I left I stayed in [my sister's] apartment and the day I left, oh, maybe four or five of the neighbors came and stood while I was getting in the car and they were all crying …and that was touching.

Finally, Naomi and I talked about the loss of independence, which emerged as an important theme for her, as it did, likewise, for other individuals in this inquiry. When I

suggested that for other interviewees, the home was a symbol of independence, Naomi agreed and provided this example:

> What I miss about not having my own home is the ability to get up when I want to get up—to eat breakfast or lunch or dinner when I want to eat. In a facility like this, there's no way they could do that. You have to have a regimentation. So it's the same old, same old everyday routine. In my case they have to put this compression hose on me and that's at 6:00 in the morning and then from then on, I go to the dining room at 7:30—whether you're hungry or not—and lunch is at 11:30—whether you're hungry or not.

Toward the close of our interview, I asked Naomi, "What is the missing piece—the thing that would catapult you into being satisfied and happy with your situation?" Suggesting the importance of this theme, she said, "Just the independence…of the whole thing. My own independence. Come and go as I pleased. Eat when I pleased—not eat if I didn't want to eat."

Another theme that resonated for Naomi, which also surfaced for other participants, was the experience of being constrained by the lifestyle offered in assisted living. When I asked if she ever felt imprisoned or inhibited by living in the facility, she said, "It rings true. Definitely. It rings true…exactly. You have to live according to the rules." Believing that a core issue underlying the experience of being constrained was a lack of autonomy and agency, I inquired of Naomi what types of decisions she still could make at Site 4. After considering the question, she mentioned that she could decide whether or not to attend the activities that the facility sponsored, but that overall, opportunities for decision making are "definitely limited." She explained, "The staff

cannot force you to do things. You have your choice, but it's only temporary choice as far as I'm concerned." She provided an example that supported her statement. A person might decide not to take a bath, she said, and if that person lived at home no one would force him or her to bathe. The person might eventually hear from friends that he or she smelled and decide to do something about it. However, at Site 4, she declared, the staff eventually would "force the person to bathe."

Naomi and I also talked about advantages of her transition to assisted living as well as factors that supported her in the adjustment process and that afforded her some sense of comfort. The primary advantage that Naomi identified was "…just the advantage of being taken care of. Doing things that I couldn't do. I couldn't be fixing a meal, because I can't stand up long enough. There would be no way I could fix a meal." This advantage also resonated with other interviewees in this study. Interestingly, though, Naomi followed this statement about the benefits of assisted living by telling me about another resident who caught her attention. "There is a woman here who has just fascinated me. If you ask her how she is, she says: 'I'm fine! I don't have to cook! I don't have to clean!' She was just delighted to be in here. And she was just—apparently, I don't know whether she didn't like cooking...and that was what her statement was—that she was just delighted." Just as Naomi was fascinated with this resident, I was intrigued by her description of "being fascinated" by a woman who seemed to be delighted to be at Site 4 and to be relieved of day-to-day household duties. Trying to understand Naomi's fascination, I asked, "…while it is an advantage, it wouldn't have been a big deal for you to do the everyday things?" She responded, "No, no. That's right. It wouldn't have been a big deal." It appeared that even the one advantage that Naomi identified was not a

significant advantage to her—if she were physically capable, she would have preferred taking care of the household duties to living in assisted living. Thus, perhaps Naomi's fascination with the other resident is partially explained by her own desires to be independent rather than have paid employees relieving her of daily chores. Naomi did not talk further about her interest in this resident, but I cannot help but wonder about other explanations for her interest. I wondered: Was it such an anomaly to find a person who was genuinely happy about living in assisted living that this person would stand out among all of the other residents? I recall a statement made by another interviewee who told me that in her facility, "…no one is really happy here. We all talk about it when we're by ourselves." The other interviewee then mentioned that there *was* one person at the facility who seemed sincerely happy about being relieved of daily chores, but "she is the only one."

The supportive factors that Naomi identified are reflective of those that emerged for other participants as well. First, she talked about maintaining and enhancing existing relationships and friendships. In spite of the physical distance between Naomi and her friends, she said, "Fortunately, I still hear from them. I am happy about that." Indeed, she told me that one couple visited her three times since she relocated, and other friend also visited. Moreover, she and her friends corresponded by mail and phone; the friends forwarded to her newsletters from their residence association; and the friends sent pictures from their social gatherings. When I asked if sustaining these relationships had an impact on her ability to adjust, Naomi declared, "Oh, yes! Absolutely. Yeah." Additionally, Naomi enjoyed the visits from her family as well as those from a few people she met during her short stay in the senior apartment. The interactions with the

acquaintances from the apartment were significant in that they "provided another outside interest." Finally, Naomi also said that her faith has been a help to her throughout her stay at Site 4. Indeed, Naomi even took the initiative to call me at my home several hours after our interview to tell me that after reflecting on our conversation, she wanted me to know how important her faith is to her. "I turn the TV on mute during all the commercials," she said, "and during that time I pray for patience about being here, and I pray for my family and my friends."

The presence of friends in her life was a significant support in the transition; however, since moving to assisted living, Naomi did not make any attempts to get friendly with the other residents. Her reasoning for not reaching out to others reminded me of what another participant said about having difficulty finding people in the facility with whom she could connect. Naomi stated, "I have not made the effort to get acquainted with anyone else from the assisted living—for no reason. I have enough to occupy myself. I don't get bored. I've got a book and the television, so I'm alright..." Seconds later, she added, "I notice that a lot of the women are ready for an argument. Maybe that's what keeps me away…." Although going to the dining room provided an opportunity for interaction with others, Naomi said, "I eat and when I'm finished I leave." According to Naomi, a number of the residents showed signs of cognitive impairment to which she attributed their "snappy" attitudes and her inability to get close to them. Finally, she said she was "discouraged" when she tried to talk to others who were hard of hearing because she often ended up being misunderstood.

To close the segment of our conversation about supportive factors, I asked Naomi about the staff at the facility. A number of other participants in the inquiry had talked

about attentive care-givers as a supportive factor in adjustment, but when I asked Naomi if she also experienced the staff as supportive, her response was striking:

> No, no. I don't think so. It kind of worked the other way. I could see that a lot of them were here just for pay. There are a lot who are caring and there a couple of nurses that are extremely caring and, oh, sympathetic to the whole situation, but on the whole, I think not. I think the administration is trying to weed out the…I mean for a while there were a couple of them that you'd say something to them and they'd snap back. One woman asked to have her bed made because her minister was coming and the aide said, 'Let him make the bed.' That kind of stuff.

A segment of my dialogue with Naomi gives a fuller picture of what Naomi was referring to and the impact that insensitive or inconsiderate staff members can have on the residents of assisted living:

> CJ: So rather than help you adjust it had the opposite effect?
>
> Naomi: It was a little bit of a turn off. I thought it would be a far cry different from the nursing home, but….They will wheel some people down in the wheelchair and because they can go faster with the wheelchair, they cut in front of the one on a walker. I know if I were the one on the walker, nine chances out of ten, I'd be on the floor.
>
> CJ: So there is a lack of consideration?
>
> Naomi: Yes…If there's company around or family around they're all buddy-buddy and 'What can we do,' but when company's not around, it's the real thing.
>
> CJ: You fend for yourself in some ways?

Naomi: Yes, yeah. I wouldn't tell on these girls because it's up to the one that it's happening to. But when you are a little bit alert you see a lot of things…

Unfortunately, Naomi did not share the experience of staff being a protective factor against the risks of transitioning to assisted living; instead, she provided a frank description of the destructive role care-givers can play when they do not approach residents with an attitude of kindness or concern.

Another theme that emerged for Naomi, as well as for a few other participants in this investigation, was related to myths or stereotypes about older adults. Almost as an aside, Naomi said at one point that she does not attend the activities because she "simply does not want to be entertained." Her simple statement hinted at a stereotype about older adults and senility. She stated, "If I could just appreciate when they come in and sing, but I feel like I'm being patronized. And that's wrong. I mean because they don't do it with that in mind." Clearly attempting to be polite and not criticize the facility or the activity director (which was another unit of meaning that arose in the focus group), Naomi nonetheless communicated a desire not to be treated as less than the competent adult that she was. Sometimes, she said, when the activity director arranged for children to come to the facility to practice playing an instrument for the residents, she and another female resident agreed that "they were just pawning them [the children] off on us," as if to suggest that the residents automatically wanted to be a captive audience for the children. Finally, I said to Naomi, "I think there are some stereotypes about older people. You're old, you don't have a mind. Let's throw some entertainment in front of you and you'll be happy." Emphatically, she said, "Yes, yes, that's right." Then, giving another example,

she said, “Yes, even with doctors. If your son or daughter-in-law is there they will tell *them* all about you instead of talking to you.”

Although not necessarily a stereotype, Naomi touched on a theme that was unique to her experience and a profound description of one of her fears about moving to a care facility. The underlying issue about which she talked related to the objectification of people in institutional settings. She stated:

> Another thing—I should bring this out. The more I thought about going into a facility in [City] [where her townhouse was located], other than having things fall on my sister and on my niece, I don’t think I wanted to be too close to all of these friends. And my reasoning was almost like—you’d go to the zoo in the summer time to see the monkeys, and I thought they might be just coming to see how I’m doing.

To help clarify what Naomi was suggesting, I inquired if she thought moving into a facility would cause her to feel “less than” her friends. After a moment, she said:

> It might have been like I was an object. Oh, let’s see how she’s doing in the nursing home. That’s what was in my mind…. so many after they moved to this one facility that was so close to us, there was no contact with anybody else. And I think I thought maybe that would happen. I wanted to try avoid being…just having people just pop in and see how I was doing and not come back again.

As my interview with Naomi drew to a close, I asked her to describe her overall sense of happiness or satisfaction with her life at Site 4. In another powerful statement, she shared this description of her emotional and spiritual state:

> Let's say I'm contented. I won't say happy. I would say contented. I say contented because this is the way it's got to be, and I'm contented that this is probably one of the better facilities. I'm contented that my son and daughter-in-law and grandchildren are aware that I'm here and are over here frequently. But I'm not at home. I'm not doing what I'd like to do. But that's not their fault. They're doing what they can to help me.

Struck by Naomi's assessment of her level of satisfaction, which certainly pointed towards a greater degree of dissatisfaction than happiness, I reflected to her that while she might be content, she still seems to yearn for something more. Her response pointed towards one last, deeply moving theme that resonated for other participants in this inquiry:

> More...that's right. And I'm not going to get it. As my son says, 'Well you're talking about everything in the past. Talk about the future.' And I said, 'I had fun in the past.' If I thought or talked about the future, I'd put a gun to my head. You know, because: *What future*? When you look at all these old people, including myself, they're just waiting to die. When you think about it…when you just sit and think about it….

With the transition to assisted living, Naomi, like others, said she "absolutely" took on a greater awareness of her impending death. "One died Christmas Eve; one died New Year's Eve," she said. "The longer you're here, the more you're aware of it. And of course, as I say, I sit with the 101 or 102 year old, and every day I wonder if she's coming down for the meals." After a certain point, she said, death is "almost…to me…a blessing."

Before summarizing the most prominent themes that surfaced in the interview with Naomi, it is important to note an aspect of the interview that was more covert than overt. In the same way that I noticed an attempt at mitigation, a sense of surrender, and discomfort with being critical of the facility or the situation of assisted living in the focus group, I noticed similar dynamics in the interview with Naomi. For instance, when she talked about her loss of independence and having to participate in "regimentation" at meal times, she followed up her sharing with the statement, "Yet, I can see that they have to do that…" Later, when Naomi talked about being patronized by the activities and entertainment at the facility, she quickly softened her statement about being patronized by saying, "And that's wrong. I mean because they don't do it with that in mind." Finally, in her description of about being contented—and not happy—at Site 4, Naomi did not want to assign any part of responsibility for her psychosocial difficulties to her children: "But that's not their fault. They're doing what they can to help me." Indeed, one might even wonder to what degree Naomi was herself complicit to the cultural context in which she lived, where a sense of independence and individualism appears to be highly protected. Her strong feelings about not living with her children and not imposing herself on them are not overlooked. Moreover, when she talked about her "contentedness" she almost dismissed the possibility for a greater sense of fulfillment and resigned herself to her situation because, as she declared, "*this is the way it's got to be*."

Table 14 summarizes the main themes the emerged in the interview with Naomi. Included among the themes are precipitating factors such as health challenges, lack of suitable options for health care, and desire not to be a burden to others. Other themes that surfaced were biopsychosocial risks related to loss of independence and freedom, loss of

personal possessions, fear of objectification, and poor treatment by staff members. Evidence of power, subjugation, and aging was apparent in themes related to attempts at politeness, desire not to criticize the facility or family, and myths and stereotypes about older adults. Finally, a number of supportive factors emerged; these surrounded the experiences of maintaining current relationships and presence of faith life.

Table 14

Summary of Intra-Case Analysis: Themes from Interview 10

	Precipitating Factors	**Biopsychosocial Risks**	**Evidence of Power, Subjugation, Aging**	**Evidence of Positive Aging/ Supportive Factors**	**Other**
	Ill health	Loss of independence/ freedom	Mitigation of the negative effects of transition	Focus on Self	Greater awareness of death
	Desire not to burden family	Fear of objectification	Surrender to the decision to transition	Maintaining existing relationships	Attitude of disregard by staff
	Lack of suitable health care options	Loss of valuable/meaningful items in the move	Feeling constrained / imprisoned by the transition	Family visits and involvement as a support	
	Prompt from children	Lack of activities that meet intellectual or social needs	Stereotypes about aging process/ older adults (elders viewed as senile)	Spirituality / faith as a support	
		Lack of social relationships within the facility			

Cross-Case Analysis: Focus Group and Individual Interviews

The cross-case analysis provides a synopsis of the multitude of themes that surfaced for all participants in this inquiry, both in the focus group and in the individual interviews. Similarities and differences in units of meaning that surfaced in five categorical areas are summarized in Tables 15-19. A separate table for each category of themes is provided for ease of review, and similarities and differences among themes in each categorical area are noted.

Thematic Similarities Related to Precipitating Factors

As evidenced in Table 15, two of the most prominent themes to emerge relating to precipitative factors in the transition to assisted living were (a) health challenges, a theme that was present for all but one participant, and (b) a desire on the part of the resident not to burden family members with day-to-day care-giving duties, a theme that was common to the experiences of all but two participants. Another aspect of meaning that emerged in the focus group as well as for seven individuals with whom I had an individual interview was the experience of the transition as part of a self-initiated decision to relocate from a home residence. It is in the category of precipitating factors and its emergent themes that the co-researchers in this inquiry are most homogenous.

Table 15

Cross-case Comparison of Precipitating Factors

	FG1	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
Precipitating Factors											
Ill health	X	X	X		X	X	X	X	X	X	X
Desire not to burden Family	X	X	X	X	X	X	X	X			X
Desire for dependable Care						X					
Self initiated decision to Move	X	X		X	X	X			X	X	X
Fear of being alone/ Falling	X									X	

Thematic Differences Related to Precipitating Factors

One theme that stands out as a unique precipitating factor was related to the desire for dependable care, about which Resident 5 talked as a primary motivation for relocation. One individual interviewee and one member of the focus group discussed the

fear of falling as a precipitating factor. The self-initiated decision also was not present for 3 participants; nonetheless, it is more a similarity than a difference among residents.

Thematic Similarities Related to Biopsychosocial Risks

Table 16 summarizes the themes related to the biopsychosocial risks related to a transition to assisted living. Although there is noticeable variability among the themes in this category, several similarities are evident. The most common risk factor for participants was the experience of losing their sense of independence or freedom; only 2 of the 13 participants did not share the experience of losing some degree of independence. Another fairly common risk factor that was shared by 5 residents was a decreased involvement in the wider community (i.e., the community outside of the assisted living facility). Five residents also talked about a sense of loneliness or isolation related to the transition. Finally, 6 residents expressed feelings of loss, grief, and mourning related to losing their homes or valued items from their homes. It is clear that when looking at the risk factors the elders in this investigation experienced, the participants are a much more heterogeneous group.

Table 16

Cross Case Comparison of Biopsychosocial Risks

	FG1	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
Biopsychosocial Risks to Transition											
Loss of Independence/ Freedom	X	X	X	X	X	X	X		X		X
Desire not to burden family with negative feelings about the transition			X								
Health decline			X		X	X				X	
Depressed temperament							X				
Decreased involvement in the wider community		X	X	X	X		X				
Role/Identity Change											
Sense of uselessness		X									
Regarding daily activities							X				
Sense of isolation		X	X		X						
Sense of loneliness		X				X	X				
Loss of valuable/meaningful items in the move		X	X				X	X		X	X
Lack of social relationships within the facility		X	X						X		X
Lack of activities that meet intellectual or social needs		X	X								X
Economic instability as a cause of anxiety			X								
Sense of dissatisfaction / unhappiness with the transition			X					X			X

Thematic Differences Related to Biopsychosocial Risks

There are a variety of risk factors that surfaced in the interviews that were unique experiences, not common to all participants. One interviewee talked about having to keep her dissatisfaction with the transition to herself and not being able to share her true feelings with her family. Two residents talked about changes in their perceived identities (being useless) or roles in day-to-day activities. Four residents experienced a lack of

social relationships within the facility that met their needs, and 3 residents also talked about a lack of activities that met their intellectual or social needs. Finally, one resident talked about economic instability as a source of anxiety, and 3 residents expressed general dissatisfaction with the transition.

Thematic Similarities Related to Power, Aging, and Subjugation

The category of themes related to power, subjugation, and aging largely was formed after some of the residents' experiences were triangulated with Gergen and Gergen's (1995) concepts related to social constructionism and Foucault's (1995) understanding of power. The areas of similarity in this category are several. Members of the focus group as well as 6 individuals in in-depth interviews talked about their transition to assisted living in a way that communicated a sense of surrender to the transition. Seven residents in individual interviews talked about how their decision accommodated their children. Members of the focus group as well as 3 individuals related to the theme of feeling constrained or imprisoned by the transition. All members of the focus group as well as 2 other individual interviewees felt pressure to adjust to the transition either by their peers or family. Finally 4 participants in individual interviews talked about stereotypes related to being an older adult or about the aging process. The similarities and differences in this category are summarized in Table 17.

Table 17

Cross-Case Comparison of Themes Related to Power, Aging, and Subjugation

	FG1	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
Evidence of Power, Subjugation, & Aging											
Opposition to the Transition	X		X								
Mitigation of the negative effects of transition	X										X
Surrender to the decision to transition	X	X		X	X	X	X				X
Necessary acclimation	X			X				X			
Decision accommodates Children			X	X	X	X	X	X			
Feeling constrained/ Imprisoned by the Transition	X	X	X	X							X
Not being heard in the decision-making process			X					X			
Lack of involvement in the decision-making process			X					X			
Stereotypes about aging process/ older adults											
Elders viewed as useless		X									
Elders viewed as senile			X								X
Elders seen as fragile / untouchable								X			
Fear that future placement decisions will be made by others					X						
Not being treated as an Adult					X						

Thematic Differences Related to Power, Aging, and Subjugation

Unique themes that emerged in the category related to power, subjugation, and aging are related to a fear that future placement decisions will be made by others and a sense of not being treated as an adult; Resident 4 expressed these concerns. Another interviewee shared that she was not actively involved in the decision making process,

while Resident 2 talked specifically about not being heard through the decision making process. Two interviewees felt an opposition to the transition. Finally, in the focus group and one individual interview, mitigation of the negative aspects of transition emerged as a unit of meaning.

Thematic Similarities Related to Positive Aging and Supportive Factors

Table 18 summarizes a category of themes labeled positive aging and supportive factors that resonated with almost every resident in some way. This category was informed by Gergen and Gergen's (2000; 2003) conceptualization of positive aging as well as Bronfenbrenner's (2005) understanding of proximal processes. Strong similarities among participants' experiences were found in the area of focusing on personal needs and development, in which focus group members as well as seven individuals in in-depth interviews identified with this theme. All of the interviewees talked about forming new relationships with either staff or residents at their facilities. Additionally, nearly all co-researchers maintained, to some extent, their existing relationships with family or with friends. Six interviewees talked about their community involvement inside of the assisted living community. Eight participants related to their faith or spirituality as a support in the transition. Finally, 4 participants said that economic stability was an important factor in making their transition to assisted living.

Table 18

Cross-Case Comparison of Themes Related to Positive Aging and Supportive Factors

	FG1	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
Examples of Positive Aging / Supportive Factors											
Focus on Self	X			X	X	X	X	X	X		X
Forming new relationships		X	X	X	X	X		X	X	X	
With staff		X	X		X	X	X				
With other residents											
Maintaining existing Relationships	X	X	X	X	X	X	X	X	X	X	X
Community involvement inside AL				X	X	X	X		X	X	
Community involvement Outside of AL				X		X	X				
Involvement in the investigation of facilities & decision making	X					X				X	X
Staff attentiveness as a Support	X	X						X		X	
Spirituality/faith as a Support			X	X	X	X	X	X	X		X
Economic Security / stability as a support		X	X	X	X						
Family visits and involvement as a support			X								
Maintaining roles after Transition									X		
Continued autonomous decision making after transition	X									X	

Thematic Differences Related to Positive Aging and Supportive Factors

Table 18 also summarizes the differences in supportive factors or evidence of positive aging that residents experienced. Resident 8 talked about maintaining her professional roles even after transition to assisted living. Resident 2 talked about the meaning of family involvement in the transition process. A theme that emerged in the focus group as well as for three other interviewees was related to the importance of investigating the assisted living facilities before relocation and being involved in the

decision making process. Finally, a theme that also emerged in the focus group and for one other resident was the explicit nature of autonomous decision making that occurred after the transition to assisted living.

Other Themes that Emerged in the Inquiry

Table 19 summarizes the themes that emerged for residents that did not fit into the four primary categories. One notable theme that surfaced for three residents was related to the experience of having a greater awareness of death and the challenges of old age as a result of the transition to assisted living. Three interviewees also talked about dissatisfaction with food as part of their transition experience. Finally, 1 individual discussed an attitude of disregard by facility staff.

Table 19

Other Emergent Themes

	FG1	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
Other											
Greater awareness of Death			X						X		X
Dissatisfaction with food		X	X							X	
Attitude of disregard by Staff											X

Chapter Summary

The results reported in this chapter emerged from one focus group interview comprised of 5 participants and ten in-depth interviews (including a follow-up interview with one member of the focus group). A total of 14 older adult residents of five different assisted living facilities participated in this inquiry. The five sites I visited represented three out of the four types of facilities that have been identified (Utz, 1999) as existing in Ohio, including free-standing assisted living facility, assisted living with nursing home

component, and assisted living as part of a continuing care retirement community (CCRC).

Throughout the process of data collection, I took notes about my experiences that related to the interviewees, the sites, the intersection of data with the theoretical framework constructed for this inquiry, and questions and hypotheses that began to arise as I reflected on and organized the data. After each interview, I transcribed the taped conversation and began to look for points of interest and themes that resonated with other interviewees' experiences or with the bioecological, motivational, and social constructionist frameworks adopted for this investigation.

The themes that surfaced in the interviews were grouped in four main categories: (a) precipitating factors, (b) biopsychosocial risks, (c) evidence of power, subjugation, and aging, and (d) examples of positive aging and supportive factors. Additionally, a fifth category labeled 'other' was added to account for emergent themes that did not fit within the four primary categories. The categories were created through the triangulation of data from group and individual interviews with the theoretical framework already identified for this investigation (i.e., bioecological and motivational) as well as a social constructionist perspective. The bioecological and motivational framework is reflected strongly in the second and fourth categories (biopsychosocial risks and positive aging/supportive factors), and the social constructionist perspective is reflected largely in the third and fourth categories (evidence of power, subjugation, and aging and positive aging/ supportive factors).

Of the five categories of themes that emerged as a description of participants' experiences, the category in which co-researchers demonstrated the greatest degree of

homogeneity was in the area of precipitating factors; almost every participant talked about a health challenge that played a role in the transition. In other categories, there were instances in which the participants' experiences resonated powerfully with one another. Some examples include the experience of a loss of independence or freedom and the loss of valuable or meaningful items in the transition (biospychosocial risks), the experience of understanding the transition to assisted living as a sensible choice to which they surrendered, if not the most personally desirable choice (evidence of power, subjugation, and aging), and the experience of maintaining existing relationships and creating new relationships (examples of positive aging and supportive factors). There also were some aspects of meaning that were unique to one or two individuals in this investigation that appeared in each category.

CHAPTER V

DISCUSSION

Assisted living is the fastest growing senior housing option today (Steinhardt, 1997), and estimates suggest that this sector of the housing, health care, and services market will continue to experience considerable growth in the near future. Moreover, demographic trends in the United States, and indeed globally, point towards a rapidly expanding population of older adults (Administration on Aging, 2006). The increasing popularity of assisted living (AL) as a long-term care option and evidence of shifting demographics provided two important reasons to study the experiences of older adults in the AL context. Other factors, such as the lack of information about the transition to assisted living, as well as research indicating that late-life residential transitions can be psychosocially problematic (Aneshensel et al., 2000; Cummings, 2002; Mead et al., 2005), provided additional rationale for this investigation. The purpose of this inquiry was to examine the lived experiences of older adults who undergo the late-stage, life-span ecological transition from a home residence to an assisted living facility. The results of this qualitative inquiry emerged from one focus group interview and 10 in-depth interviews with a total of 14 older adult residents at five separate assisted living sites.

In this chapter, I open a discussion about the preliminary findings by reflecting on the canvas of participant experiences and the body of new information that emerged in the study. The discussion is framed within the four primary categories of themes that surfaced in the focus group and individual interviews: (a) precipitating factors; (b) biopsychosocial risks of transition; (c) evidence of power, subjugation, and aging; and (d) examples of positive aging or supportive factors. For each of these four areas, I first draw

conclusions from the data and then offer hypotheses and questions for further research. Hypothesis generation is inherent to qualitative research (Levers, 2002). Details of the data and nuances in experience that are able to be observed through qualitative methods open up opportunities for the researcher to "enhance understanding of phenomena, inform relevant questions, and generate new hypotheses" (Levers, 2002, p. 30). Finally, cultural implications are considered, limitations of the inquiry are noted, and recommendations for future research are proposed.

Interpreting Finding 1: Precipitating Factors

The first major category that emerged in this study deals with the reasons why older adults transitioned from their homes to assisted living facilities. The discussion below focuses on three principal factors that led participants in this investigation to leave their homes, namely, health challenges, the desire not to burden others (especially family), and self-initiation in the decision to relocate.

Health Challenges

One of the most consistent findings in this investigation is the role that health challenges play in the transition to assisted living. Given the advanced age of most participants, and the likelihood that they would have encountered a health challenge as they aged, this finding was not altogether surprising. Consistent with prior research (Cummings, 2002), the findings of this study form a picture of aging adult residents of assisted living as individuals who have encountered health ailments that impose limitations on their ability to perform the daily tasks associated with living in their homes. Some of these tasks include household upkeep (e.g., cleaning and laundry), cooking, personal care, grocery shopping, and care-giving duties for a spouse. The

severity of health challenges varied among the older adults. Some participants experienced health problems serious enough to warrant hospitalization and then rehabilitation in a nursing home, while others had minor set-backs they were able to overcome, but nonetheless, that triggered reflection about their ability to continue to care independently for themselves in the future. Without physical health limitations, however, most of the participants in this investigation likely would not have made the transition to assisted living when they did.

Desire not to be a Burden

Another precipitating factor in relocation was the participants' desire not to be a "burden" to others, especially to adult children. Taken at face-value, this theme could be viewed as an expression of the interviewees' sensitivity to the context of their children's lives. Many of the participants' adult children were married and faced a variety of responsibilities for their children, grandchildren, and spouses. From this perspective, the elders' desire not to be a burden could be interpreted as an act of consideration for children who have very busy and full lives. However, I suspect that a more profound issue about American and Western cultural values related to individualism and independence (Gergen & Gergen, 2000) lies at the center of this theme.

Using the interviewees' statements as a guide, it seems that on one level not wanting to impose on one's children was a self-protective act. For instance, in a very genuine way, Resident 8 stated that relocating to assisted living enabled her to protect her own privacy and sense of independence. On another level, not wanting to be a burden appeared to be an act of self-sacrifice for elders who did not wish to become a hindrance to *their children's* independence. Several interviewees believed that their children had the

right to “live their own lives” and stated that they would “never” consider jeopardizing their children’s independence.

Whether an act of self-protection or an act of self-sacrifice, I surmise that the issue at play in the desire not to become a burden to others is a reflection of American values on independence and individualism. Gergen and Gergen (2000, ¶ 2) suggested that when cultural values center on individualism, aging adults become a burden, an imposition, and even a “dead weight” on family members when they encounter health challenges. In many ways, health problems present a contradiction to the ‘myth’ of individualism. As much as older Americans who live within a Western value system treasure individualism and try not to impinge on others’ freedom, the near impossibility of maintaining an independent lifestyle is evident as they face health setbacks. Ill health can reduce both the older adult’s independence and the family members’ sense of individualism as they begin to provide care for older relatives.

Clearly, participants in this study were uncomfortable imposing on their relatives’ independence and preferred to take whatever action was necessary not to become “dead weights.” Not to be a burden or a dead weight, as Gergen and Gergen (2000) stated, means “preserving one’s individuality, and this entails not asking for greater connection to family members” (¶ 3). Caught between the reality of physical health challenges and American values on individuality, older adults in this investigation turned to assisted living, a solution which may have been attractive not only because of the practical services it offered (e.g. personal care tasks), but also because of what it symbolized: a continuance of independence and individualism for the older adult whose independence was being challenged by health problems.

Self-Initiated Decision to Relocate

Another consistent theme that emerged as a precipitating factor in the transition to assisted living is the elders' decision that the time simply had come for them to relocate. As I reflect on the results of the study and try to identify key elements in a healthy adjustment to assisted living, the statements interviewees made about a *self-initiated* transition process seem to be particularly important. Indeed, based on the experiences of the participants, I would speculate that the degree to which participants were satisfied with the transition was related to the degree to which the participants experienced a sense of autonomy in the decision making process.

In attempting to understand the role of autonomy in a positive adjustment, I turn to Ryan and Deci (2000; 2006), who proposed a theory of self-determination to explain the inherent desire for autonomy, agency or individual directedness, which they suggest all people possess. According to Ryan and Deci (2006), autonomous acts are "endorsed by the self, fully identified with and 'owned'" (p. 1561). Moreover, in underlining the central importance of autonomy to the human experience, the researchers propose, "…autonomy is considered a basic psychological need (along with relatedness and competence), and thus its effects on well-being are expected to be pervasive" (Ryan & Deci, 2006, p. 1565) In this inquiry, the residents who embodied the greatest sense of wellness all had described self-initiated, autonomous decisions to relocate to assisted living. For instance, Residents 5 and 8 both pondered their housing and care options before moving and also visited facilities of interest prior to their move; both of these individuals struck me as being well-adjusted and satisfied with their transition to assisted living. Moreover, both individuals exhibited more examples of positive aging than

biopsychosocial risk factors. In another instance, Resident 9, who professed that she "makes all her decisions," including the decision to relocate, mentioned that had another person forced her to relocate, the process of adjusting probably would not have been as easy as it was.

As I reflect on what Resident 9 said, I am reminded of the experiences of Residents 2 and 7, who described being excluded from active involvement in the decision making process of moving to assisted living. After five years of living at her site, Resident 2 still seems angry about how the transition to her facility occurred, and my overall impression of this co-researcher is that she is deeply dissatisfied with her life in assisted living. Resident 7 also seemed to be frustrated with life in assisted living, and admitted, "I can't tell you truly that I'm happy here…." In consideration of self-determination theory and the portraits of adjustment that emerged from the participants in this inquiry, I surmise that the role of personal agency in making the decision to transition is important to an individual's subsequent ability to adjust to the relocation, engage in a normal developmental process, and experience an overall sense of well-being.

Interpreting Finding 2: Biopsychosocial Risks and Adjustment to the Transition

A second major category of findings organizes the themes related to the various biopsychosocial concerns that elders encountered as a result of the transition to assisted living. The most common or the most striking barriers to well-being were (a) the loss of independence; (b) isolation, loneliness, and lack of meaningful social interactions; and (c) the absence of appropriate activities. A number of other themes also surfaced, including mental health concerns such as depression and anxiety, however, the discussion will be limited to the three themes mentioned above.

Loss of Independence

Among the most notable risks to development that emerged in this inquiry was the loss of independence. In trying to make sense of this aspect of the transition experience, one question first must be addressed: What did the interviewees mean by independence? Self-determination theory draws a specific distinction between the terms independence and autonomy, where independence implies a cultural value on individualism, and autonomy connotes a basic human need for choice and self-directedness, regardless of cultural leanings toward collectivism or individualism.

After thoroughly reviewing the interview transcriptions, I see evidence that the phrase "loss of independence" was used to refer to shifts in living out cultural values around individualism as well as to changes in the experience of autonomy or self-directedness. Residents 3 and 5 both spoke of the loss of independence in ways that suggested that the transition to assisted living brought greater dependence on others than they previously had known, but did not necessarily reduce their fundamental decision-making ability. Both of these residents talked about the loss of independence in relationship to giving up their cars when they moved to assisted living. They no longer were able to "come and go as I please", which seems to indicate they still could *decide* where to go but may have had to rely on others to accomplish their desires. The loss of independence, when experienced as a loss of self-reliance, presented a barrier to well-being and a potential risk to the process of growth and normal development. However, for most of the residents who experienced this type of loss, the barrier did not appear to be insurmountable. Resident 5, for example, was accepting of the fact that he had to arrange rides with friends in the community to go to meetings and church gatherings.

Likewise, Resident 4, who talked about a loss of independence, also capitalized on supportive factors, such as opportunities for transportation that his facility made available to him so that he could engage in activities outside of the assisted living community.

In other cases, elders clearly talked about the loss of independence in a way that connoted a loss of autonomy. In the focus group, as well as in some individual interviews, participants talked about not being able to "set their own schedules" or make decisions for how to live their day-to-day lives. They also talked about having to adjust to a "regulated way of living". Resident 10 addressed the loss of independence directly in terms of choice. She stated, "We have choice, but it's only temporary as far as I'm concerned…," which meant to her that the staff and administration ultimately had the ability to override a resident's decision. Similarly, Resident 2 talked about the loss of independence as a loss of agency. "I have to do what I'm told to do—when I am told to do it," she stated. For Resident 2, the loss of autonomy was intricately tied with the loss of her home, which was deeply symbolic. "It meant freedom—my own way of living," she said of her home. The loss of independence that residents perceived as a loss of agency seemed to present an even greater risk to development and healthy adjustment than the loss of independence that was perceived as a loss of self-reliance. Residents who experienced the loss of autonomy seemed to feel powerless over the administrative system and unable to control rudimentary daily decisions; these residents also seemed dissatisfied or not 'at peace' with their lives in assisted living. For instance, Resident 10 stated, "Let's say I'm contented. I won't say happy. I would say contented. I say contented because this is the way it's got to be….but I'm not at home. I'm not doing what I'd like to do…." Ryan and Deci's (2006) theory of self-determination provides one

frame of reference for understanding the challenges a person might face in an environment that is not autonomy-supportive. However, because the findings from this research are only preliminary and based on a small group of participants, future research may be able to examine more specifically the relationship between lack of autonomy and the 'discontentedness' that seemed to characterize some interviewees' transition experience. Thus, a question that arises for further exploration is: To what extent is an autonomy supportive environment related to elders' ability to engage in a normal developmental trajectory when they transition into an assisted living facility?

Loneliness, Isolation, and Inadequate Social Interactions

Another potential risk to biopsychosocial health in the transition to assisted living was the absence of social connectedness and meaningful relationships. In this inquiry, several interviewees talked about loneliness as part of their transition experience. For some participants, the experience of being lonely was most strongly present during the initial (first several weeks or months) stage of the relocation. Once these individuals began to meet other residents, the sense of loneliness seemed to subside. Their experiences could be considered clinically appropriate psychological reactions, and the sense of isolation or loneliness that they encountered could be described as a typical part of an adjustment process. However, more information about the impact of this psychological reaction to the transition is needed. A question for further research that arises, therefore, is: In what ways does loneliness inhibit the normal developmental process of elders who transition from their homes into assisted living facilities?

For other co-researchers, the experience of being disconnected was more profound and never truly receded. Resident 1, who lived in her facility for a year and a

half, said, “You don’t know what loneliness is until you come to one of these places!” The experience of isolation also was evident for a number of residents who did not seek out, and even purposely avoided, forming relationships with other elders in their environments. In general, the residents who expressed a lack of connectedness with others in their facilities exhibited greater numbers of risk factors than examples of positive aging. Additionally, these individuals seemed less satisfied with the transition experience than older adults who forged meaningful relationships with other men and women in the assisted living community.

In trying to understand how the experience of loneliness and social isolation occurred in assisted living, several explanations emerged. First, differences in physical health among residents of the assisted living facilities acted as a barrier to social relationships. Resident 10, for example, said that her tablemates in the dining room were hard of hearing, which made conversation among them very difficult and discouraged her from initiating dialogue. Second, differences in cognitive awareness and ability acted as a potential obstacle to relationships. For instance, Resident 10, who is a very alert woman, observed that many individuals in her facility seemed quite forgetful , and she found it difficult to connect meaningfully with others who were not as alert as herself. Third, socio-economic status emerged as a potential threat to social relatedness. Resident 1, for example, believed differences in socio-economic status acted as a barrier to finding a “social match.” Finally, three participants talked about not wanting to create meaningful social connections because of their heightened awareness of death and loss. Resident 10 declared, “When you look at all these old people, including myself, they’re just waiting to die…the longer you’re here, the more you’re aware of it.” Resident 2, who resided in

assisted living longer than any other resident, declared that she purposefully stays in her room because it is too painful to continue getting close to people at the facility only to watch them die.

Barriers to social connectedness are of potentially great risk to residents of assisted living. Cummings (2002) reported that factors affecting assisted living residents' sense of well-being include their perception of social support; residents who perceive greater social support and meaningful relationships describe correspondingly higher levels of satisfaction. The bioecological model of human development (Bronfenbrenner, 2005) and self-determination theory (SDT; Ryan & Deci, 2000; 2006) provide another layer of concern for lack of social connectedness. In the bioecological model, "[t]he relations between an active individual and his or her active and multilevel ecology constitute the driving force of human development" (Lerner, 2005, p. xix). Thus, social relationships and the pattern of activities in which a person engages play a prominent role in development and can invite, allow for, or stall human change. Similarly, SDT (Ryan & Deci) purports that social relatedness is a basic, human psychological need, and in the absence of social relatedness, people are less able to activate their innate motivations towards growth. Given the importance of social relatedness to well-being and the presence of barriers to social connectedness that emerged for participants in this inquiry, a question arises: In what ways can elders, staff, and administrators in assisted living facilities enhance opportunities for meaningful, social interactions that can be maintained over time? I have to wonder, in particular, what support systems are available to residents in their grieving processes when they are faced with the deaths of community members

and friends and how changes, adjustments, and additions to existing systems could help residents manage the loss of significant relationships.

Inadequate or Inappropriate Activities

Another barrier to development and well-being that emerged in this inquiry has to do with the condition of the assisted living environment, and more particularly, with the types of activities that are present in the environment. A number of residents in this inquiry suggested that the slate of activities that the facility provided did not meet their needs for intellectual, emotional, and social stimulation. For instance, Resident 1 stated that she did not want to participate in activities in which she was asked to "take stickers and put 'em on buckets and boxes and tie ribbons…." Resident 2 declared, "…I'm not interested in the kinds of stuff they do…it reminds me of being in kindergarten…I call it simplistic…they treat us like we can't think…." Finally, Resident 10 concurred and stated that she does not attend activities because she "simply does not want to be entertained" and admitted that she feels "patronized" by the activities.

Relying once again on developmental and motivational perspectives (Bronfenbrenner, 2005; Ryan & Deci, 2000; 2006) to help make sense of the emergent themes in this inquiry, the shortcomings of the environmental activities can be viewed as a potential hindrance to development and well-being. Based on the noted theoretical frameworks, I suspect that the range of activities in the immediate context of the dissatisfied residents probably provided older adults with entertainment or 'busy work' but may not have supported or challenged the residents towards further expressions of motivation and growth potential. Self determination theory purports that the pattern of activities in a person's environment, when seen as interesting, instructional, or as tapping

into a personal value and preference set, can promote motivation and, hence, growth potential and well-being (Reeve, 2006). Reflecting on this proposition, I cannot help but be reminded of Resident 8, who said that one of the reasons she adjusted so easily and quickly is because the staff at the facility inquired about her interests as soon as she moved into Site 3. Upon learning of her background as a librarian, the administrators immediately invited her to help coordinate and run their library. This type of activity seems to have tapped into Resident 8's interests and values, and even may have contributed to her experience of competence. This type of social activity clearly was providing more than entertainment to Resident 8. In light of the experience of Resident 8 and the experiences of the residents who were not challenged by the activities at their sites, I hypothesize that older adults who are resilient and age positively do so in part because they are in facilities (environments) with conditions that support their basic psychological needs by providing activities that lead to greater autonomy and sense of competence.

Interpreting Finding 3: Power, Aging, and Subjugation

I have organized another set of themes of profound interest to this inquiry around the concepts of power and subjugation. Gergen (1995, p. 29) suggested that the concept of power is "rhetorically hot." He cautioned that, "To thrust it [power] into the centre of analysis is to raise a red flag, suggesting that existing arrangements are replete with oppression and inequity, and that fundamental change is required" (Gergen, 1995, p. 29). Yet, the intent of creating a discussion about facets of the transition phenomenon that relate to the concept of power is not *necessarily* to throw the red flag. Heeding Gergen's pronouncement, I move with caution in proposing interpretations around a collection of

themes that touch on the following areas: cultural myths and stereotypes about aging and older adulthood, subjugation and surrender, and imprisonment.

Cultural Myths and Stereotypes about Aging and Older Adulthood

While interviewing the co-researchers in this investigation, I became aware of the presence of cultural stereotypes about older adulthood that were part of the participants' lived experiences. I identified three stereotypes: (a) older adults are senile; (b) older adults are useless; and (c) older adults are fragile and incompetent. Resident 2 specifically addressed the myth of senility in a statement about her frustration with the types of activities that the facility provided for residents. "I call it simplistic…," she said about the activities. "They treat us like we can't think!" Resident 10 also talked about being "patronized" by the slate of activities. Finally, Resident 1 said that with her move to assisted living she experienced "total uselessness".

Bronfenbrenner's (1979; 2005) bioecological model accounts for the influence of macrosystemic elements, such as cultural myths, beliefs, and stereotypes, on human development. The negative connotation attached to the stereotypes that surfaced for these residents is noticeable, and the role that such stereotypes play in an older adult's transition experience is potentially powerful. I suspect that there is a strong connection between an older adult's biological health and evaluations that are placed on his or her psychological health. Specifically, I hypothesize that failures in biological health influence the promulgation of negative assessments of mental ability. For instance, Resident 2 described a period of hospitalization during which she was "tested" for cognitive awareness by her grandson. Even more striking is Resident 2's story of relocation, which seemed to convey that because of her physical setbacks, influential

people in her life formed a negative perception about her mental competence, and consequently, excluded her from dialogue about the decision to move to assisted living.

Holstein and Gubrium (2000), (as cited in Gergen & Gergen, 2003, p. 205) stated that to "find someone biologically or cognitively impaired constitutes a…*collaborative accomplishment*. It is an accomplishment of particular professional groups working with particular assumptions and values, within a complicit culture." The complicit culture to which they are referring is a culture laden with negative presumptions about the aging process as well as assumptions about older adulthood as a period of decline. The preliminary findings of this study provide some evidence that negative stereotypes about older adults, when supported by a complicit culture, have the potential to rob elders of their autonomy. Further investigation in this area certainly is needed. A question for future research may be: How do negative stereotypes about older adults have an impact on their involvement in decision-making processes during moments when they face health challenges and hospitalization?

Surrender and Self-Subjugation

Another macrosystemic factor that seems to have played a significant part in the transition phenomenon is a socially constructed belief system in a "naturalized life course" (Gergen & Gergen, 2000; 2003). Gergen and Gergen (2000; 2003) described the naturalized life course as an attempt to explain human development through growth and decline tendencies. Development begins in childhood, reaches maturity in early and middle adulthood, and declines in old age. When viewed from this perspective, old age *primarily* is equated to degeneration. The wide-spread nature of a socially constructed, naturalized life course is undeniable. Phrases that appear in everyday conversation, such

as “over the hill” and “out to pasture”, remind us that older adults are unproductive and have little to offer. Resident 1 put it this way: “Your useful years are over. They are. By all stretches.” Gergen and Gergen (2003) observed that professional groups and academics, such as gerontologists and medical professionals, also promote the naturalized life course by publishing journal articles about older adults or the aging process that focus largely on physical decline and ailment.

In this investigation, some participants were not just aware of cultural beliefs in older adulthood as a degenerative phase of life, but some of them even seemed to surrender to this taken-for-granted worldview. For example, Resident 3 first reported that she independently decided to move to assisted living, but she shortly later admitted that, “The children feel easier. It was just the idea of driving on snow and ice in the winter, which I would probably do if I were out. The children, I know, felt like it was time for me to quit driving in the winter.” With this statement, Resident 3 seemed to hint that her decision to relocate was not as independent as she would have liked to have thought. Later, she stated, “The children are at ease that I’m here. That doesn’t mean I wouldn’t rather be out in my condo with my car!” And then, “I don’t think most people come in because they see this as a great way to live. They come in because it’s a sensible way to live, and it’s proving to be that.” Finally, she stated, “It wouldn’t be my choice of a way to live if I weren’t old. Let’s put it that way….” Resident 3 was the only participant in the investigation who did not move to assisted living because of an impending health problem for which she needed attention from nurses and care-takers. Reportedly healthy, Resident 3 moved primarily because she was old, and she was supported in her decision by her children, who seem to be at ease with her decision to withdraw from her active life

in the community. Somehow, it seems that Resident 3 may not have transitioned to assisted living because she truly wanted to make the move, but because she surrendered to the 'fate' of decline that accompanies old age.

Like Resident 3, Resident 1 also provided an example of how older adults themselves can become complicit with the belief systems about decline in late-life. Resident 1 vocalized an implicit expectation that she *should* leave her home because she required outside help for her physical care and material upkeep. When I talked with this participant about the changes in her relationship with her children after her move to assisted living, she laughingly said, "They thought: She did it on her own! Let's hurry up and get her in there before she changes her mind….I know that's what was going through their mind. One of them had a friend who was going through the same thing, and his mother-in-law would not go anywhere, and she was causing all kinds of problems. I kept saying to [Son], 'Why in the world doesn't she just check in?'" Perhaps most interesting is Resident 1's belief that older adults, including herself, should surrender to the culture of decline in old age. In fact, her view of an older woman who would not leave her home for facility living was that the woman was a trouble maker who "was causing all kinds of problems."

From a social constructionist perspective, cultural beliefs, such as the naturalized life course, can be understood as an issue of power. Summarizing Foucault's (1995) ideas, Gergen described one type of power as "the incorporation of belief systems within subject populations" (1995, p. 35). From this perspective, power is not defined by 'brute force,' but rather, by sets of belief systems that are created, sustained, and promoted by certain organizations, cultures and cultural actions. People eventually begin to participate

in their own suppression by internalizing limiting stereotypes, beliefs, and myths. "As the system of discourse, often taken to be truth or knowledge by its advocates, becomes the argot of everyday activity, seeping into the capillaries of the normal or taken for granted, so does the aggregate become complicit in its own subjugation." (Gergen, 1995, p. 35). None of the elders in this investigation were forced from their homes into assisted living. However, some elders themselves appeared to be complicit with a culture in which aging is equated with decline and the transition to assisted living becomes a symbol that they surrendered to inevitable decline.

Life on "The Rock"

Finally, a remarkable theme that was embedded within some of the interviewees' stories is the experience of being imprisoned. Three participants compared life in assisted living to "being in jail", being "locked up", and being in a "first class prison"; a couple other interviewees, when asked about this metaphor, agreed that the description fit their experience. Feeling trapped in their facilities, some of the interviewees were looking for ways out. As Resident 1 shared with me, one of her good friends is "her freedom…her method out." Resident 2 jokingly said that if she were younger she would try to "escape." The image of assisted living as prison is striking; the pain expressed by some of the interviewees who made such descriptions of their experience *is* worth noticing. Before dismissing this metaphor, it seems important to listening to the often muted voice of the subjugated elder.

In some ways, the prison experience was related to the reality that the residents were not permitted to have a vehicle at their site or the fact that they no longer could drive on their own, and therefore, they felt confined inside of the facility. On a more

profound level, a few residents talked about this theme in terms of the "regimentation" and "regulations" that were part of the facility environments. Resident 2 introduced the idea that she experienced an absence of freedom and described a division of power between herself and the administration; she talked about "her time" versus "their time" and "her rules" versus "their rules." Despite the fact that most residents made the "independent" decision to move, there still seemed to be a part of them that spilled out in protest to their situation of "being in jail" or "locked up". This theme brings to light one of the paradoxes of the transition to assisted living. Although the majority of interviewees relocated in order to salvage part of their independence, they nonetheless were at risk to feel imprisoned by the environment. Gergen (1995) noted the importance of dialogue and relationship to creating balanced relationships. Perhaps further exploration about means of enhancing open, honest dialogue between residents and administration could contribute to a more genuine connectedness between these two parties and, importantly, add to a greater sense of balance in decision making endeavors that directly involve residents of assisted living facilities.

Interpreting Finding 4: Positive Aging and Supportive Factors

The results of this investigation provide numerous examples of risk factors that older adults face in the late-life transition process from their homes into assisted living facilities. The shared experiences of the interviewees indicated that some participants appeared to be complicit with Western cultural values that long have supported and promoted a naturalized life course in which decline is accepted without question as part of old age. Another American value that played a dominant role in the transition

experience for most participants related to individualism. In most instances, the powerful belief in individuality was a motivating factor for the transition to assisted living.

Yet, not every experience of transition to assisted living was characterized by risk factors. In fact, for some participants, the relocation to assisted living offered more benefits than problems. One of the tasks of this chapter is making sense of the variability in experiences that emerged in the data. In order to try to understand the differences in experience, I turn again to the theoretical frameworks that have served this inquiry.

Social Constructionism and Aging Positively

The theoretical approach known as social constructionism operates out of the assumption that "the ways in which we describe and explain the world are not demanded by the nature of the world itself. Rather, it is through the active negotiation and collaboration of people that such understandings are constructed" (Gergen & Gergen, 2003 p. 204). Using this perspective, Gergen and Gergen propose that the process of aging need not be *naturalized* into a human journey of growth and development (in childhood), maturation and productivity (in adulthood) and degeneration and decline in older adulthood. Moreover, the researchers posit that there already are emerging in society ample examples of older adults who epitomize human development as a life-long *growth* endeavor. By not succumbing to the culturally constructed, naturalized explanation of aging as a period of decline, new possibilities for positive aging emerge.

It seemed important in this investigation to be sensitive to instances in which the transition to assisted living offered the co-researchers opportunities to continue to develop in positive ways. Because there were abundant signs that elders did continue to engage themselves and their personal interests, their relationships, and even provide

service to the facility community (three life themes that are dominant in the experience of positive aging), the idea of positive aging helped to provide a framework to understanding the growth-supportive experiences (Gergen & Gergen, 2003).

One of the most outstanding examples of positive aging emerged in the story of Resident 8. At 90 years old, this determined lady took the initiative to sell her home and relocate to assisted living only after she had investigated the suitability of the facility to her needs. She professed the importance of creating many interests for oneself that largely were aimed at her self-enhancement. Focused on the pursuit of her happiness, Resident 8 took up gardening and decided to learn how to water paint after moving to her facility. In an activity that was aimed at her own pleasure as well as the betterment of the community, Resident 8 became actively involved in the library as soon as she moved into the facility, and of her own accord, created a catalog system for the couple thousand books the facility owned.

A second example of positive aging that stands out from the inquiry is evident in the life experience of Resident 4. Like Resident 8, this older gentleman sought out ways to achieve self-satisfaction. Purchasing an expensive camera, Resident 4 determined that he would take up photography. He also took advantage of the outings and activities that the facility offered because he enjoyed them. Finally, he focused on fostering the joys of relationship and spoke fondly of a significant relationship with a woman in the facility; he sincerely seemed to derive pleasure from the friendship and to place great value on it.

An important observation that can be made about these two stories is that old age need not be a period of decline. The life stories of residents of assisted living who seek out opportunities for their own pleasure, create new relationships and enhance their

existing relationships, and provide service to others stand as a strong example that human development is a life-long process. The taken-for-granted worldview that negatively has shaped our cultural beliefs about older adulthood also can be reshaped by as elders continually decide not to surrender to the myth of decline.

Supportive Factors in the Transition to Assisted Living

Examples of positive aging in the transition to assisted living clearly are evident. In trying to make sense of how some older adults were able to engage their life-span positively, it is useful also to consider the environmental supports that allow for positive development in the transition to assisted living. Just as certain factors in the transition presented risk factors to development, other elements buoyed older adults who left their home residences for assisted living facilities. Two of the most universal or significant themes surround relatedness and autonomy.

Relatedness.

In numerous ways, older adults described the theme of relatedness as a vital part of adjustment and continued development after the transition to assisted living. Almost all of the residents maintained some contact with family members or friends after they relocated, and the role that these relationships played in adjustment was significant. Resident 10 said that receiving phone calls and mail as well as personal visits from her friends in the wider community was "absolutely" part of her ability to adjust. For Resident 9, knowing that her relatives offered to take care of any needs she had was extremely important.

Forming new and meaningful relationships also was a factor in older adults' ability to experience a normal social trajectory. Resident 5, who evidenced more

examples of positive aging than risk factors, said that he began to feel adjusted or part of the community after getting to know other residents at his site. Specifically, he talked about striking up a friendship with another woman at the facility with whom he played scrabble for several hours every afternoon. Like Resident 5, Resident 4 formed a significant and meaningful relationship with another adult at his facility, and this relationship seemed to mitigate feelings of loneliness or isolation. Other new relationships that participants formed were with caring staff members, and these relationships, too, acted as supports. Resident 9 offered one of the most striking examples of the importance of forming positive relationships with the staff when she talked about how important it was to her that the administrator of her site called each resident by name. "It means to me that she knows who I am, and I certainly know who she is. It means a real family…," she said. Based on the various types of relationships that interviewees formed, I speculate that maintaining and creating experiences of relatedness is a key factor in helping older adults through the transition to assisted living.

Autonomy.

A second factor that emerged as important to the residents in managing the transition to assisted living was the ability to make autonomous decisions. Like the theme of relatedness, the aspect of autonomy appeared in various forms. The residents who appeared to embody the best transition experiences were those who had the opportunity to engage fully in the decision-making process of leaving their homes for an assisted living facility. A fully-engaged decision-making process was characterized by the older adults' involvement in various steps of the transition process. Residents 5, 8, and 9, for example, talked about visiting facilities before they left their homes. Resident 8 also was

completely immersed in the choices she made about which of her possessions to take with her and which to leave to her children. She even described a process of cataloguing her household items so she knew which of the items she would take to her site. For these residents, the decision to relocate was marked by more than mere "agreement" with other, well-meaning individuals in their lives who proposed that assisted living would be a suitable choice when they needed additional care. Rather, for these individuals the choice to relocate was one with which they fully identified and one that they owned.

Not every participant in this inquiry had the opportunity to be fully involved in the decision-making process to transition from their homes to assisted living. Particularly when sudden or serious health problems arose, some participants found themselves in a position of needing greater care than what was available to them at home. A couple members of the focus group, as well as Residents 2 and 6 are such examples. However, even in this group of individuals, the importance of autonomy to their well-being emerged as important. A member of the focus group who seemed to be mourning her lost autonomy stated, "I think I've lost my sense of being independent. Not altogether, I still have independent thinking…." Resident 2, who lamented the state of feeling imprisoned, said, "You don't have any say so…." but then declared, "but I don't do everything they tell me to do." Finding ways to make personal choices seemed to assist these residents with the risks to independence they encountered.

Cultural Considerations

The population of older adults often is considered as a special population or cultural group in its own right in counselor education literature (e.g., Gladding, 2003). By focusing on the experiences of older adults, this investigation, to some degree, can be

viewed as a multiculturally-oriented inquiry into a particular facet of the late-life experience of older Americans. The findings of the inquiry expand the knowledge base about residents of assisted living facilities (ALFs) and highlight the risk and supportive factors that are part of the transition from a home residence to an ALF.

On the other hand, it is also important to reflect on the cultural diversity of the individual participants who were part of the inquiry. One of the most interesting observations that I made in each of the five sites I visited was the distinct lack of racial diversity among the population of residents. Not only were all of the *participants* in this inquiry White Americans, but it appeared that most of the *residents* in the facilities were White. In some respects, the lack of diversity among the interviewees can be viewed as a limitation of this investigation. However, it also is a piece of data that calls for interpretation and that raises questions for further research.

The lack of racial diversity should be considered, first, in relationship to the accessibility of assisted living to minority elders and those of lower socioeconomic status. Assisted living is an expensive housing option that, by and large, is private-pay. Even with the installation of a new Assisted Living Medicare Waiver Program in Ohio, which is intended to increase utilization of assisted living by the economically disadvantaged (who also are more likely to be minority elders), the Ohio Department of Aging (2006) acknowledged that the group of older adults who relocate to assisted living is not likely to become more diverse in the near future.

With limited financial resources acting as a barrier for minority elders who need care services of the type provided by assisted living, I reflected on another potential explanation that emerged in the data. A large portion of the interviewees in this inquiry

wanted to maintain a sense of self-reliance, and at the same time, avoid becoming a hindrance to others' freedom. However, I could not help wondering if this theme would have been as consistent if the demographic make-up of the participants in this investigation had been more racially diverse and, in turn, more representative of varying cultural values about care-giving for older adults. For example, in an investigation of the living arrangements of immigrants to the United States, Wilmoth (2001, p. 229) stated that, "Cultural norms in those countries that advocate self-determination, independence, and individualism encourage increased residential privacy…," while in populations where "the norms regarding individualism are not as strong," multigenerational housing arrangements are more likely to appear. The researcher noted that adults of Western European heritage, who value the nuclear family unit, tend to live alone as they age, while elders from Central and South America as well as Asia and Eastern Europe are inclined to live in multigenerational households (Wilmoth). Wilmoth's statement about the impact of cultural values on living arrangements for older adults seems to suggest that, least to some extent, a difference in values on individualism can help to explain why few racial minority elders resided at the five sites I visited. Further exploration is needed to examine the reasons that minority elders under-utilize assisted living, and additionally, to investigate the lived experiences of minority elders who undergo late-life residential transitions. Several questions for future research emerge: (a) To what extent do racial and cultural values within the broader American demographic influence the ways that people are socialized to think about what is acceptable in care-giving for older adults? (b) How do value systems among older, ethnic minority populations influence the ways they utilize assisted living as a health care option when they are faced with health challenges?

(c) In addition to financial status, what barriers, prevent racial minority groups from utilizing assisted living facilities? (d) How do racial minority groups perceive health and housing community services, such as assisted living, as responding to the needs of their older adults? and (e) How do minority groups currently care for their aging elders?

Implications

The findings of this investigation have implications for older adult residents who transition to assisted living from a home residence. Some of these implications have been discussed in the analysis of the major emergent themes. However, the bioecological model of human development, which inherently accounts for a diversity of proximal and distal factors on development, suggests that, as the researcher, I must look at the meaning of the transition experience for older adults to as well as consider how the findings can be of use to other key figures and systems in the transition phenomenon. Additionally, the research design of this investigation was guided by van Manen's (1997) concepts of lifeworld existentials (lived space, lived human relationship, lived body, and lived time). As van Manen proposed, using these categories as interpretive tools creates focal points from which many threads of understanding and hypothesis generation can emerge. Thus, in this section I reflect on the meaning of this inquiry's findings for professional counselors and for administrators in the assisted living industry.

Implications for Professional Counselors

Professional counselors are expected to practice proficiently with clients from various cultural backgrounds. Older adults often are considered to be a unique population, and counselors who meet the standards of multicultural competence (Sue, Arredondo, & McDavis, 1992) must strive (a) to become aware of their biases,

stereotypes, and beliefs about elderly people, (b) to become knowledgeable about the diverse population of older adults, and finally, (c) to create interventions that are appropriate to the needs of elders. This investigation provided fresh insight into a subset of the elderly population, namely, elders who transition into assisted living facilities from their home residences.

Cultural competence with older adults—awareness.

Working competently with a diverse population first requires counselors to reflect on their attitudes and beliefs about the target population. In this investigation, a number of limiting attitudes about older adults emerged, including myths about senility, fragility, incompetence, and uselessness. Additionally, the cultural belief in a naturalized life course (Gergen & Gergen, 2000; 2003) characterized the worldview about the aging process that some older adult participants and people in their immediate environments espoused. Counselors who work with older adults and especially with residents of long-term-care facilities may want to be particularly attentive to the stereotypes about elders and the aging process that emerged in this investigation and that clearly were a negative influence on the lived experiences of the participants. Moreover, before engaging in therapeutic relationships with ALF elders, counselors need to evaluate their own understanding of human development, especially late-life development, as the findings of this inquiry suggested that a belief in a naturalized life course can act as a barrier to older adults' growth potential.

Cultural competence with older adults—knowledge.

A second aspect of multicultural competence involves gaining knowledge about diverse client populations (Sue et al., 1992). Literature on multiculturalism (e.g., Sue &

Sue, 2003) provides counselors with impressions of or statements about cultural groups' values, beliefs, practices, and communication styles based on research findings. However, the literature cautions counseling professionals not to make assumptions about individual clients based on generalizations about the client's cultural background. In support of this caution, one of the strongest findings of this inquiry is that, in many respects, older adults who transition to assisted living are not a homogenous group. In particular, the results of this investigation suggested that personal perceptions and psychoemotional reactions of older adults to the transition experience vary. Therefore, culturally competent counselors must make an effort to learn about residents' individual, psychological and affective responses to the transition to be able to empathize accurately and create sensitive interventions.

Although the results of this investigation supported the individualized nature of participants' psychoemotional reactions to the late-life transition to assisted living, there also were a number of barriers (risk factors) and supportive factors characterizing the context of the transition experience that are of use to counselors. Being knowledgeable about the risks, such as lack of autonomy, sense of isolation, and non-supportive or inappropriate activities, and the supportive factors, including sense of directedness and relatedness, can help professional counselors begin to formulate effective interventions with residents of assisted living.

Cultural competence with older adults—skills.

The third aspect of cultural competence involves creating appropriate interventions for diverse client groups (Sue et al., 1992). The findings of this investigation lend themselves to a number of recommendations for culturally-sensitive

clinical interventions. First, the central importance of autonomy to participants' well-being, sense of life-satisfaction, and motivation toward growth was evident in the cross-case analysis of risks and supportive factors. Counselors who work with residents of assisted living thus are recommended to assess the level of self-directedness that resident-clients experience. In particular, counselors are recommended to inquire about the precipitating factors surrounding clients' transitions to determine the extent to which the older adults willingly consented to or self-initiated the relocation. Residents whose transitions are marked by a sense of coercion may face greater difficulty tapping into internal motivation for psychological growth and development. If the transition to assisted living is initiated by persons other than the client-resident or if occasions for residents to meet their need for autonomy within the ALF are limited or absent, counselors may help clients by acknowledging and empathizing with the feelings of distress that often are created when people do not feel in control of their own lives. Assisting residents to reevaluate their daily routines in order to identify hidden opportunities for acting autonomously is one way counselors can help residents foster internal motivation and a sense of personal control.

A second recommendation for creating culturally-appropriate clinical interventions is that professional counselors respond to residents' apparent need for relatedness. One striking theme that emerged from this investigation as an explanation why elders in assisted living disengaged from interpersonal relationships with fellow residents is their heightened awareness of death and loss. Implementing strategies, such as grief and loss groups and annual or biannual memorial ceremonies for ALF elders who have died, may help residents deal with the impact of multiple losses they encounter.

These strategies also may renew residents' desires to create new relationships after suffering the loss of friends and acquaintances in their ALF communities.

Understanding some of the biopsychosocial aspects of the transition experience, as well as the environmental supports that aid in a positive transition, will help professional counselors who work with the population of older individuals. In addition, this investigation provided evidence that creating opportunities for residents to meet their basic psychological needs (Ryan & Deci, 2006), such as autonomy and relatedness, is an important factor in ALF elders' ability to tap into their innate motivational tendency towards growth.

Advocacy for residents of assisted living.

A growing movement in the counseling profession involves advocating on behalf of clients. For example, the role of advocacy is particularly strong among school counselors, whose national model includes four specific themes, one of which is advocacy (ASCA, 2006). Advocacy efforts are activated for clients who are unable or limited in their ability to self-advocate for systemic change. In the realm of counseling older adult residents of assisted living facilities, advocacy is extremely relevant. A powerful theme that emerged in this investigation was the disparity in power that some participants felt; they described the power imbalance in the metaphor of assisted living as prison. In light of this metaphor, I am doubtful about some residents' capacity to self-advocate, especially for increased opportunities for autonomy in ALFs. Thus, counselors who are able to understand and empathize with residents who are not reaching their developmental potential may be well-positioned to advocate on their behalf for systemic change in assisted living facilities. Specifically, advocacy efforts could involve

counselors creating workshops for staff members and administrators of assisted living facilities about the risks and supportive factors related to the transition to long-term-care sites. Other advocacy strategies might involve practitioners in consulting directly with site coordinators or directors about ways to increase opportunities for positive aging within ALFs.

Implications for the Assisted Living Industry

Another, macro-level set of implications that arises from this investigation is related to the assisted living industry and its approach towards care services. Rosalie Kane (2001) challenged individuals and organizations, such as long-term-care providers, social workers, professional counselors, and all those who work on behalf of older adults in institutional settings, to advocate for care services that stretch beyond minimum health and safety standards. Long term care, she stated, should be provided within the framework of *quality of life*. It is not unrealistic to say that, based on at least several of the interviews in this study, there are older men and women currently residing in assisted living facilities who would not agree that they are living meaningful and purposeful lives. In this inquiry, some adults genuinely were dissatisfied at their sites; others were contented but not happy; and still others actually felt imprisoned within their "home-like" facilities. One important question that these experiences raise for me is: How can the assisted living industry, whose philosophy is to promote autonomy and dignity, become *more* than a provider of health care?

Lived space: Assisted living as home.

It seems that if the philosophy of creating a context that supports older adults' autonomy, independence, and dignity is fully engaged, then greater, more genuine and

sensitive efforts must be put towards creating opportunities for older adults to live autonomously. The assisted living industry strives to create home-like settings in its facilities. To help elders feel "at home", ALF administrators would do well to be in touch with the existential definitions of home that are important to elders. For older adults in this study, the home was a powerful symbol of freedom, volition, and choice. Although many of the participants described feelings of loss for the things they left behind in their houses, on the whole, they struggled more deeply with the loss of self-directedness that was an inherent part of their lived space in their home residences. If industry providers want elders to experience ALFs as 'home-like', a space for them to live self-determined lives must exist. Efforts to create a home-like environment must extend beyond the physical surrounding in which residents live. I speculate that the more administrators and staff of ALFs can engage their constituents creatively in day-to-day decisions, the more residents will feel satisfied.

Lived relationality: Residents, staff, and administrators.

van Manen (1997) spoke of lived relationality as the "lived relation we maintain with others in the interpersonal space we share with them" (p. 104). Assisted living providers offer elders a congregate living opportunity and, at the same time, try to create a home-like setting for people to live out their late-life years. Congregate health care environments and home-like settings are concepts not easily married, especially given the historical precedent set in nursing homes for providing health care from a medical-model approach. In a medical-model approach, there is greater likelihood for staff-resident relationships to be characterized by power differences in which staff ultimately exercises authority. Although assisted living espouses a service attitude towards health care, the

industry's ability to achieve its ideal seems, at times, to be limited. The themes that emerged in this investigation related to power, and the metaphor of assisted living as prison, evidence imbalances in power among residents and staff in some facilities. An important task for providers of long term care is to assess the *lived relation* between residents and the staff with whom they share their interpersonal space. If providers stand behind their philosophy of valuing older adults' dignity, privacy, and autonomy, it seems that they must find ways to solicit feedback from their residents about their lived relationships with AL caregivers. In some cases, inviting an independent worker, such as a counselor, social worker, or consultant may be advantageous in getting candid descriptions of residents' relationships with those who work in the assisted living facility.

Lived body: Residents as persons with dignity.

The lifeworld existential that van Manen (1997) described as "lived body" reminds us that all human encounters occur first as bodily encounters. Initial reactions and judgments often are made in response to a person's bodily presence. The participants in this inquiry raised important issues about how they, as elderly individuals, are prone to being encountered negatively by others in their environments. One resident said that she was treated as "fragile" and as a person who must not be touched. The connection between bodily appearance, health challenges and negative assessments of older adults' mental health also was present. These aspects of assisted living residents' experiences already elevate concern for *how* older adults are seen and treated by others in their environments. van Manen further proposed that "when the body is the object of someone else's gaze, it may lose some of its naturalness… (p.104). One participant in this inquiry made a striking statement about not wanting to relocate to assisted living because of her

fear that others would see her as an object. One of the most detrimental risks for staff and administrators of ALFs is that they begin to objectify residents. Thus, training for ALF staff that sensitizes caregivers to the *human* quality of the late-life experience seems of potentially great importance. I would speculate that facilities in which caregivers and administrators are successful at not pursuing negative assessments of residents simply based on physical limitations also will house residents who are happy and who report a sense of life-satisfaction.

Lived time: Search for purpose.

A final reflection for the assisted living industry and its administrators is related to van Manen's (1997) description of lived time. Lived time refers to *felt* time, not necessarily to clock time. A number of participants in this study talked about being increasingly aware of the "ravages of old age" with their transition to assisted living; the residents had greater awareness of impending death, and some felt as if they were just waiting to die. For these participants, the sense of felt time seemed to reflect a belief that old age primarily is a period of decline in which one waits for death. Directors of ALFs who take into consideration older residents' experiences of lived time may encourage staff and activity directors to create opportunities for elders to engage in meaningful activities that can help to define the tone of lived time as purposeful.

Hypotheses Generated

This section reviews the major hypotheses that emerged in this inquiry. Most of the hypotheses are tied closely to the themes that embody the results of this investigation, and thus, directly relate to the lived experiences of older adult residents of assisted living facilities (ALFs). Other hypotheses about broader, systemic issues related to cultural

elements of the transition, key figures in the relocation process (e.g. residents' family members, administrators of assisted living facilities and professional counselors) or institutions involved in the transition also surfaced. The following hypotheses emerged from the discussion: (a) The degree to which older adults feel satisfied with their lives in assisted living (AL) is related to the degree to which they experienced a sense of autonomy or directedness in the decision-making process to relocate to assisted living; (b) Residents who are able to form meaningful, sustainable relationships with others in the assisted living community are better able to develop positively than residents who do not form significant relationships in the AL setting; (c) Older adults who are resilient and age positively do so in part because they are in facilities (environments) with conditions that support their basic psychological needs by providing activities that lead to greater autonomy and sense of competence; (d) Failures in older adults' biological health influence the promulgation of negative assessments of their mental ability and decrease the likelihood of their being involved in relocation decisions; (e) Belief in a naturalized life course that equates the aging process primarily with decline has the power to act as a limiting factor in older adults' ability to make autonomous decisions related to late-life transitions; (f) Facilities in which caregivers and administrators are successful at not pursuing negative assessments of residents simply based on physical limitations also will house residents who are happy and who report a sense of life-satisfaction.

Limitations

With any investigation, there are limitations. In this inquiry, one of the first limitations to emerge was related to personal constraints I faced as the primary

researcher. Specifically, some of these limitations were related to constraints in time, financial resources, and psychological and emotional energy.

Besides personal limitations, there were theoretical constraints. I acknowledged at the beginning of Chapter 4 that the analysis and interpretation of data in this investigation largely were influenced by an ecological and motivational framework (Bronfenbrenner, 1979; 2005) that accounts for individual (Ryan & Deci, 2000) and environmental factors. Results also were considered in light of social constructionist ideologies (Gergen & Gergen, 2000; 2003). The theoretical frameworks that I chose as interpretive tools provided some ways to understand the experiences of the participants who transitioned from their homes to assisted living. However, if I had employed other theoretical models with which to triangulate the findings through the analytic process, new interpretations may have emerged and broadened the understanding of the phenomenon.

Next, there were limitations due to the sample size. Small sample size often is viewed as a drawback in qualitative research inquiries because the generalizability of the findings is limited. The findings of this investigation, which are based on focus group and individual interviews with 14 older adults, cannot be used to make broad statements about adults in assisted living facilities.

Finally, a goal of this investigation was to listen to the voices of older adults about their transition experience to assisted living, but the voices of older minority adults is distinctly absent from the preliminary results. From the beginning of this investigation, achieving racial, ethnic, and even gender diversity among participants seemed unlikely, and indeed, at the conclusion of the study, all of the participants were White and most were women. In fact, I observed populations of largely White older adults throughout all

of the facilities. The homogeneity of the participants limits this study's ability to further understand the interplay between culture and the way racial minorities utilize the assisted living housing and care option.

Recommendations for Future Research

Several recommendations for future research emerged from the findings of this inquiry. A first, broad question for consideration is: How can assisted living facilities provide accommodations for residents' apparent need for autonomy and relatedness? A second important question for future consideration is: How can older adults and the people in their immediate contexts, such as family members, create opportunities for autonomous decision making in the preparation for a transition to assisted living? Future studies may proceed by examining more closely the opportunities for decision making that exist in assisted living environments.

Several other questions emerged in the discussion of results from this study. The following questions provide direction for continuing the examination of the factors that enhance as well as detract from late-life development after a transition to assisted living: (a) To what extent do racial and cultural values within the broader American demographic influence the ways that people are socialized to think about what is acceptable in care-giving for older adults? (b) How do value systems among older, ethnic minority populations influence the ways they utilize assisted living as a health care option? (c) To what extent is an autonomy supportive environment related to elders' ability to engage in a normal developmental trajectory when they transition into an assisted living facility? (d) In what ways can elders, staff, and administrators in assisted living facilities enhance opportunities for meaningful, social interactions that can be

maintained over time? (e) What support systems are available to residents in their grieving processes when they are faced with the deaths of community members and friends and how changes, adjustments, and additions to existing systems could help residents manage the loss of significant relationships? (f) What barriers exist that prevent racial groups besides White older adults from utilizing assisted living facilities? (g) How do minority racial groups perceive health and housing community services, such as assisted living, as responding to the needs of their older adults? and (h) How do minority groups currently care for their aging elders? Examining these questions will help to ensure that older adults can capitalize on the opportunities for development that can be offered by a late-life transition to assisted living rather than be placed at risk for psychosocial problems.

Conclusion

The intent of this inquiry was to illuminate the question: How do older adults experience the late-stage, life-span ecological transition when they move from a home residence to an assisted living facility? In order to answer this question, I conducted group and individual interviews with a total of 14 older adults who resided in five separate assisted living facilities. The sites represented three-out-of-four different models of assisted living (AL) that exist in Ohio, and therefore, reflected the variability in assisted living type that is characteristic of the AL market in Ohio, as well as across the country. The older adult participants all had transitioned from a home residence to assisted living and cognitively were able to reflect upon their experiences; thus, they seemed to be well-suited to share intimate and trustworthy reflections about the late-life transition to assisted living that was of interest in this investigation.

The results of the investigation largely reflect the older adults' lived experiences of the transition to assisted living. Fairly consistent findings emerged about the reasons that elders move to assisted living, and in this area, the group of participants was the most homogeneous. Health problems contribute much momentum to the transitioning process, as, it seems, do Western cultural values on individualism. The findings also illuminated environmental concerns about social disconnectedness and a lack of challenging and meaningful activities within assisted living communities that have the potential to act as barriers to AL residents' positive development. Another concern for elders who relocate to assisted living is the potential loss of autonomy when real and perceived opportunities for self-initiated and owned decisions are not readily available to residents. On the other hand, the results of this study also provided evidence that opportunities for personal enhancement, relationship development, and community service are possible for elders who live in assisted living. These factors, which contribute positively towards human growth and development in the late-life stage and which confront cultural stereotypes about older adults and the aging process as a period of decline, are bolstered when older adults are in autonomy-supportive environments, have opportunities to forge meaningful relationships, and engage their sense of competence.

As the population of older adults continues to rise globally, the concerns of elders who relocate to care facilities become increasingly urgent. Some older adults who transition into assisted living do experience many positive opportunities for development. Others, however, struggle to find a sense of peace and satisfaction about their situations. This investigation provides an opportunity for professional counselors, social workers, long-term-care providers and all paraprofessionals who are in daily contact with older

adults in care facilities to continue to study the effects of late-life transition on older men and women and to advocate for their quality of life.

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APPENDIX A

Letter to Directors of Assisted Living Facilities

Dear Director,

Last year, the 2005 White House Conference on Aging (WHCoA) named among its top 50 research initiatives studies into improving the recognition and treatment of mental health issues among elders as well as investigations related to issues of housing among older Americans. Assisted living facilities (ALFs) are the fastest growing segment of the senior housing market; however, little is known about the factors that are associated with the transition and adjustment experiences of older adults who relocate to assisted living facilities.

I have received permission from the Duquesne University Institutional Review Board for the Protection of Human Subjects to study this topic.

Consequently, I am writing to seek your permission to invite residents at [Name of Facility] to participate in a study investigating the transitional experience associated with the relocation from a home residence to an assisted living facility. Insights gained from the investigation will contribute to the body of literature related to elders' development and mental health needs. Additionally, information gathered may be used to make recommendations for interventions that fit assisted living facility elders' needs and add to their quality of life as long term care residents and consumers. These recommendations will be made available to you and your facility at the close of the study.

Participants in the study will be asked to be part of a focus group interview and/or an individual interview, each lasting approximately one hour. All participants will be assigned a code that is known to no one except the researcher, and although the interviews will be tape-recorded, the recording will be heard only by the researcher and will be destroyed upon completion of the study. All responses and identities of participants will be kept strictly confidential. If residents decide not to take part in the study or change their minds during the study, they will not encounter any penalty, and data collected from those participants will be discarded.

Additionally, the name of your facility and any of its identifying characteristics also will be disguised in the final report generated from the study.

Thank you very much for considering this request, and I look forward to hearing from you at your earliest convenience. I can be reached at: 614-866-2859 (w.), 740-973-9298 (c.) or by email at: chrissyjungers@hotmail.com. Additionally, feel free to contact my dissertation committee member, Dr. Lisa Lopez Levers, at: 412-396-1871., or by email at: levers@duq.edu.

Sincerely,

Chrissy Jungers, M.S. Ed., LPC, NCC
Doctoral Candidate, Department of Counseling, Psychology, and Special Education

APPENDIX B

An Examination of the Transition from a Home Residence to an Assisted Living Facility

Study Description

Last year, the 2005 White House Conference on Aging (WHCoA) named among its top 50 research initiatives studies into improving the recognition and treatment of mental health issues among elders as well as investigations related to issues of housing among older Americans. Assisted living facilities (ALFs) are the fastest growing segment of the senior housing market; however, little is known about the factors that are associated with the transition and adjustment experiences of older adults who relocate to assisted living facilities.

I have received permission from the Duquesne University Institutional Review Board for the Protection of Human Subjects to study this topic.

I am inviting you to participate in a study investigating the transitional experience associated with the relocation from a home residence to an assisted living facility. Insights gained from the investigation will contribute to the body of literature related to elders' development and mental health needs. Additionally, information gathered may be used to make recommendations for interventions that fit assisted living facility elders' needs and add to their quality of life as long term care residents and consumers.

There are two parts to this study. The first part, in which all interested participants will be asked to be involved, entails participants answering a number of questions that the researcher will ask. Some of these questions will focus on demographic

information. Depending on the pattern of your responses and on the researcher's needs, you may be asked to take part in the second part of the study, which involves being a member of a focus group interview and/or participating in an individual interview. Each of these activities will last approximately one hour.

All participants will be assigned a code that is known to no one except the researcher, and although the interviews will be tape-recorded, the recording will be heard only by the researcher and will be destroyed upon completion of the study. All responses and identities of participants will be kept strictly confidential. If residents decide not to take part in the study or change their minds during the study, they will not encounter any penalty, and data collected from those participants will be discarded.

Thank you very much for considering this request. I can be reached at: 614-866-2859 (w.), 740-973-9298 (c.) or by email at: chrissyjungers@hotmail.com. Additionally, feel free to contact my dissertation committee member, Dr. Lisa Lopez Levers, at: 412-396-1871, or by email at: levers@duq.edu.

Sincerely,

Chrissy Jungers, M.S. Ed., LPC, NCC
Doctoral Candidate, Department of Counseling, Psychology, and Special Education

APPENDIX C

Semi-Structured Interview Guide for Focus Group Interview

1) How have you adjusted to living in an assisted living facility after leaving your home?

2) What are the factors that eased the transition for you?

3) What things "got in your way" or made the move to an assisted living facility difficult?

4) Tell me about the changes in the relationships in your life since your move, for example, with your family members, peers and friends, staff in the facility, and other residents.

5) How has the move had an impact on your physical health?

6) Is there anything else you would like to tell me about the transition you made into this assisted living facility?

7) What recommendations would you make to the directors of your facility as aids in making the transition process easier and smoother?

APPENDIX D

Semi-Structured Interview Guide for Individual Interviews

1) What has the move to an assisted living facility meant to you personally?

2) Have you discovered any benefits to moving that you did not anticipate?

3) Is there anything about the move to assisted living that surprised you?

4) How has the move had an impact on your social relationships and who you spend time with?

5) How has the move to assisted living had an impact on your perceived roles in the social environment or your sense of identity?

6) How has the transition had an effect on your financial situation?

7) How has the move to assisted living had an impact on your physical well-being?

8) When you moved to assisted living, did you have to give anything up that was of value to you (e.g., possessions, activities, social relationships, activities)? Tell me about those things.

9) What has been the most difficult part of moving to assisted living?

10) What factors helped you the most to adjust to your new living arrangements?

11) What suggestions would you make to other men and women who are contemplating relocating from their homes to an assisted living facility?

APPENDIX E

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Lived experiences of older adults: Examining the ecology of transition from a home residence to an assisted living facility

INVESTIGATOR: Christin Jungers, M.S. Ed., LPC
1478 Terry Dr.
Reynoldsburg, OH 43068
(614) 759-8820 (hm) / (740) 973-9298 (cell)
chrissyjungers@hotmail.com

ADVISOR: Dr. Jocelyn Gregoire
Duquesne University
Department of Counseling, Psychology and Special Education
110 F Canevin Hall
(412) 396-4442
gregoire@duq.edu

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in the Executive Counselor Education and Supervision Program at Duquesne University.

PURPOSE: You are being asked to participate in a study that is intended to examine older adults' experiences of the transition from a home residence to an assisted living facility.

There are two parts to this study. If you agree

to participate, you will be asked to be involved in the first part, which entails answering a number of questions, some of which involve basic demographic information about yourself. Depending on the pattern of your responses and on the researcher's needs, you may be asked to take part in the second part, which involves being in a focus group and/or participating in an individual interview, each of which will last approximately 1 hour. The interviews will focus on the transition from a home residence to an assisted living facility. The interviews will be taped and later transcribed by the researcher, Christin Jungers. These are the only requests that will be made of you.

RISKS AND BENEFITS:

Risks to participating in this study are minimal, and may include feelings such as sadness, loss, or discomfort when talking about the transition experience. However, these risks are not believed to exceed those that may be encountered in daily activities. Should you want counseling services now or in the future, you may contact the following professional counselors: Leslie Slagel, M.S., Ed. (412-973-1928); Mariellen Kerr, M. Ed. (412-953-2542).

Although you may not experience any immediate, personal benefits of the study, the research should help to provide information that will help others better understand the important issues related to a late-life transition to an assisted living facility.

COMPENSATION:

There will be no compensation associated with

this study. At the same time, participation in the project will require no cost to you.

CONFIDENTIALITY: Your name and identity will be protected. No identity will be made in the data analysis. When audiotapes are transcribed, all identifiers related to you or anyone you talk about will be deleted or coded. Only the researcher, Christin Jungers, will have access to the code that identifies you. After transcription, tapes will be immediately destroyed or erased.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw at any time and should you choose to withdraw, you may request that the information that has already been collected be destroyed.

If you would like more information or are in any way dissatisfied with the process of the research study, you may contact the researcher, Christin Jungers (home- 614-759-8820; cell – 740-973-9298; email – chrissyjungers@hotmail.com). You also may contact Dr. Jocelyn Gregoire, the dissertation advisor for this study (office – 412-396-4442; email – gregoire@duq.edu) or Dr. Paul Richer, the Institutional Review Board Chair, at Duquesne University (office—412-849-4306; email—richer@duq.edu).

SUMMARY OF RESULTS: A summary of the results of the study will be available to you at the completion of the study at no cost to you, upon request.

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw from the study at any time and for any reason. On these terms, I state that I am willing to participate in this research project. There will be no adverse consequences should you decide not to participate.

_____ _____

Participant's Signature Date

_____ _____

Researcher's Signature Date

APPENDIX F

Demographic Information Form for Residents

Name_____

1. Age: _____

2. Gender (*please circle one***):** Male Female

3. Race/Ethnicity: _____

4. Education Level (*please circle one***):**

a. Elementary School b. High School c. Some College

d. College Degree e. Graduate Degree

f. Other:_____

5. How long have you resided in this assisted living facility?:

_____

6. Did you move to this assisted living facility from your home residence (house, apartment, condominium, etc.)? (*please circle one***)**

Yes No